S. HRG. 100-453

IMPLEMENTATION OF THE OMNIBUS DRUG ACT

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

OVERSIGHT HEARING ON IMPLEMENTATION OF THE OMNIBUS DRUG ACT

NOVEMBER 5, 1987
WASHINGTON, DC

U.S. GOVERNMENT PRINTING OFFICE
81-930 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S411-12

SELECT COMMITTEE ON INDIAN AFFAIRS

DANIEL K. INOUYE, Hawaii, *Chairman*
DANIEL J. EVANS, WASHINGTON, *Vice Chairman*

JOHN MELCHER, Montana	FRANK H. MURKOWSKI, Alaska
DENNIS DeCONCINI, Arizona	JOHN McCAIN, Arizona
QUENTIN N. BURDICK, North Dakota	
THOMAS A. DASCHLE, South Dakota	

Alan R. Parker, *Staff Director*
Patricia M. Zell *Chief Counsel*
Joe Mentor, Jr., *Minority Counsel*

CONTENTS

Statements of:

Page
Antone, Donald, Sr., Governor of Gila River Indian Community and President of Intertribal Council of Arizona, Phoenix, AZ 4
Arviso, Katherine, Director, Division of Health Improvement Services, Navajo Nation, Window Rock, AZ 9
Blackhawk, John, Aberdeen Tribal Chairman's Health Board, Aberdeen, SD 47
Charlie, Kenneth B., chairman, Alaska Native Health Board and member, the Tanana Chiefs Conference 23
DeGross, Dennis P., executive director, Alaska Native Health Board 23
Elbert, Hazel, Deputy Assistant Secretary for Indian Affairs, Tribal Services, Department of the Interior 34
Evans, Hon. Daniel J., U.S. Senator from Washington, vice chairman, Select Committee on Indian Affairs 1
Kauffman, Jo Ann, director, Seattle Indian Health Board, Seattle, WA 19
Lennox, William, Drug Abuse Prevention Oversight Staff Director, Department of Education 37
Lone Fight, Edward, chairman, Fort Berthold Tribal Council, New Town, ND 2
Naff, Nadene, councilperson, Colville Tribal Business Council, Nespelem, WA 21
Nibbs, Wisdom, Jr., chairman, Cheyenne-Arapaho Business Committee, Concho, OK, ... 7
Paulson, Susan, chairman, Tribal Action Plan 2
Rhoades, Dr. Everett, Director, Indian Health Services, Department of Health and Human Services 29

APPENDIX

Prepared statement of:

Albuquerque Area Tribal Coordinating Committee 166
Antone, Donald, Sr. (with letter) 56
Arviso, Katherine 68
Blackhawk, John 159
Charlie, Kenneth B 100
Elbert, Hazel (with attachment) 117
Kauffman, Jo Ann (with attachment) 78
Lennox, William (with attachment) 144
Lone Fight, Edward 51
Naff, Nadene (with attachment) 84
Nibbs, Wisdom, Jr. (with letter) 64
Rhoades, Dr. Everett (with attachment) 107

Additional material submitted for the record:

Problem statement of the Three Affiliated Tribes 184

IMPLEMENTATION OF THE OMNIBUS DRUG ACT

THURSDAY, NOVEMBER 5, 1987

U.S. Senate,
Select Committee on Indian Affairs,
Washington, DC.

The committee met, pursuant to notice, at 2:51 p.m., in room 485, Russell Senate Office Building, Hon. Daniel K. Inouye (chairman of the committee) presiding.

Present: Senators Inouye, Burdick, Daschle, Evans, and McCain.

STATEMENT OF HON. DANIEL J. EVANS, A U.S. SENATOR FROM WASHINGTON, VICE CHAIRMAN, SELECT COMMITTEE ON INDIAN AFFAIRS

Senator **Evans** [acting chairman]. We will now turn to the hearing on implementation of Public Law 99-570, the Anti-Drug Abuse Act of 1986. We are also going to review the activities that have been undertaken by the Bureau of Indian Affairs, the Indian Health Service, and the Department of Education in carrying out each department's responsibilities under the act.

We have asked the agencies to provide the committee with a status report as to what steps have been taken thus far to implement the directives of the act and what remains to be done. If there is a need for additional resources to effectuate the achievement of the act's objectives, we wish to be informed of the need, and the amounts that are estimated to be required. If there are obstacles in the act to the effective implementation of its goals or problems associated with its implementation, we ask the agencies to identify those obstacles and to identify solutions to such problems if they have them.

Ultimately, the most important aspect of the overall effectiveness of alcohol and substance abuse, prevention and treatment rests with the Indian community. Community involvement in every phase of education, treatment, rehabilitation and aftercare is critical if patterns of overuse and abuse amongst Indian youth are to be changed. The development of tribal action plans is the first step in assuring that tribal communities play an active role in the manner in which education and treatment programs are to be established and administered.

The response of IHS directors to the juvenile alcoholism and substance abuse prevention, education and treatment initiative has been enthusiastic, and as the number of tribal resolutions authorizing the development of tribal action plans—350, in fact—would indicate, Indian communities are eager to stem the tide of growing incidents of abuse and associated health problems, including a high rate of suicide, among Indian youth.

The problem of Indian juvenile alcohol and substance abuse is a problem that Indian people have long recognized and a problem which cries out for a solution. The Congress has acted in response to that need, and we now ask the Federal agencies to tell us how we can assist them in taking the next steps.

We have three panels today that we are delighted to welcome to this oversight hearing. I will ask panel No. 1—I hope we have enough chairs there for panel No. 1—to come forward.

Mr. Edward Lone Fight, Chairman, Fort Berthold Tribal Business Council, New Town, ND; Mr. Donald Antone, Governor, Gila River Indian Community Council, Sacaton, AZ; Ms. Nadene Naff, Councilperson, Colville Tribal Business Council, Nespelem, WA; Mr. Wisdom Nibbs, Jr., Chairman, Cheyenne-Arapaho Business Committee, Concho, OK; and Ms. Katherine Arviso, Director, Division of Health Improvement Services, Navajo Nation, Window Rock, AZ.

Welcome to the committee. We will begin in the same order that I have introduced the panel. All of your full statements will be included in the record in their entirety, and you may proceed as you wish in terms of your oral testimony. We introduced first Mr. Edward Lone Fight.

STATEMENT OF EDWARD LONE FIGHT, CHAIRMAN, FORT BERTHOLD TRIBAL BUSINESS COUNCIL, NEW TOWN, ND, ACCOMPANIED BY SUSAN PAULSON, CHAIRMAN, TRIBAL ACTION PLAN

Mr. LONE FIGHT. Thank you, Mr. Chairman. My name is Edward Lone Fight, Chairman of the Tribal Business Council of the Three Affiliated Tribes in the State of North Dakota.

I would like to thank the Chairman and the committee for this opportunity to bring our concerns before you. I would also like to commend you for your sensitivity to Indian issues and your sincerity in carrying out your oversight responsibilities. This oversight hearing provides us with the opportunity to express our concerns that cannot be addressed in other ways.

The Three Affiliated Tribes view Public Law 99-570 as a very important step towards the recovery of our tribe from the devastating effects of alcoholism and substance abuse. Section 4205 and Section 4206 have given us the structure and cooperation needed to effect change. We support the mandate of the law and these working mechanisms established by it. The law ensures coordination and cooperation by key people and agencies, which is essential to finding solutions. Prior to this law the Bureau of Indian Affairs, Indian Health Service and the tribe had no specific mandate or mechanism to work together.

The law is based on a tribe using a community approach. The assumption is that the Three Affiliated Tribes must assume the responsibility for solving the problems of chemical dependency on the reservation. This community approach is an appropriate methodology that has been proven to be effective in fighting alcoholism and substance abuse. The law has been instrumental in mobilizing the Three Affiliated Tribes for this critical battle.

The implementation of this law has its merits, but more must be done for change to occur. The areas of concern for implementation are given below. Specific data and statistics on the severity of alcoholism and substance abuse on the Fort Berthold Reservation are provided in Supplement 1, which I will not go into, but it will be made part of my statement.

No. 1, inpatient treatment remains the greatest unmet need for the Three Affiliated Tribes in combatting alcohol and substance abuse. A regional youth treatment center site was not selected in the Aberdeen area. Presently we have no treatment center and no way to provide for treatment for the young people of our reservation. We will be utilizing the monies provided by Section 4227 to provide outpatient treatment to three rural communities. However, not all youth will benefit from outpatient treatment because they require more intensive inpatient services. Thus, the result is that many of our youth will continue to struggle with the problems of alcoholism.

No. 2, we have substandard juvenile detention facilities. The requirement of detaining youth separate from adults necessitates placing them in the solitary confinement cell. The detention environment for youth is more restrictive than that of adult offenders. Thus, the need for the tribe to have a juvenile detention center is obvious; however, no information has been forwarded to the Three Affiliated Tribes regarding Section 4220 by the Bureau of Indian Affairs. This lack of communication has meant that the tribe does not know how to access rehabilitation monies for juvenile detention centers.

No. 3, Section 4218 communication has also been limited. Currently the Bureau is requiring training in child protection teams; however, our tribe has been doing child protection training for two years. Therefore, the need exists to conduct a comprehensive training needs survey to determine the actual needs for respective tribes. All North Dakota tribes presently have access to multidisciplinary team training from the University of North Dakota through a child welfare training grant. For North Dakota tribes, Section 4218 monies could have been used to address other unmet training needs.

No. 4, the intent of the law identified youth as the targeted recipients of services. With limited resources, it is cost-effective to focus prevention efforts on the young people; however, we view successful treatment of parents as the primary prevention mode for youth. Alcoholism is a family disease and therefore it is necessary to provide parents access to inpatient treatment for youth prevention to become a reality.

No. 5, approximately one-fifth of the Three Affiliated Tribes' contract health care budget is used to treat tertiary consequences of alcoholism, yet no money is allocated to prevent these consequences by providing intervention and primary treatment before the onset of complications.

No. 6, the service delivery system on the Fort Berthold Reservation is very problematic. The Garrison Dam divided the reservation into five distinct communities separated by water and distance. The cost requirements to provide services to these communities is great in time, travel, money and staff. If the communities were centrally located, less resources would be required to service the population. These unique characteristics require individual attention that resource allocation criteria cannot address.

No. 7, Section 4212 has provided curriculum purchases and counselor training that are important areas to address. However, the limited time frame of one year is not adequate to provide stability. For the Three Affiliated Tribes these monies are restricted to Bureau-funded and Bureau-operated schools. Thus, half of our young people will not have access to the curriculum purchases and counselors.

The following recommendations are a result of the concerns addressed above. These suggestions will maximize the intent of the law as it is being implemented. The Three Affiliated Tribes are sincere about fighting their own alcoholism and substance abuse battles. These proposed recommendations will help the tribes reach their goal of a sober society.

One, we recommend that contract care dollars be made available and optional for treatment as an alternative to regional treatment centers.

Two, we recommend that the Bureau of Indian Affairs provide better accountability to ensure communications for development of programs by the Tribal Action Plan Committee.

Three, we recommend that planning, schedules, and continuity of training programs be for more than three years.

Four, we recommend that funds be appropriated for Indian children attending non-Bureau funded schools on reservations. It is further recommended that those non-Bureau funded public schools located on reservations be mandated to cooperate with Tribal Action Plan Committees.

Five, we recommend that adequate funding levels be appropriated for all sections of the law to ensure stability and success of the programs.

And six, we recommend that service delivery problems on rural and isolated reservations be given special consideration.

Thank you, Mr. Chairman. This concludes my statement. I would be happy to respond to any questions. I have with me Susan Paulson, who is the chairman of our Tribal Action Plan.

[Prepared statement of Mr. Lone Fight appears in the appendix.]

Senator EVANS. We are delighted to have you testify. We will go through the rest of the witnesses and then have an opportunity for questioning of the entire panel.

Mr. LONE FIGHT. Thank you very much.

Senator EVANS. Second, Mr. Donald Antone.

STATEMENT OF DONALD ANTONE, SR., GOVERNOR OF GILA RIVER INDIAN COMMUNITY AND PRESIDENT OF INTERTRIBAL COUNCIL OF ARIZONA, PHOENIX, AZ

Mr. ANTONE. Thank you, Mr. Chairman. My name is Donald Antone. I am the Governor of the Gila River Indian Community and President of the Intertribal Council of Arizona. We deeply appreciate this opportunity to comment on the progress of the implementation of the Indian Alcohol and Drug Abuse Prevention and Treatment Act of 1986.

The legislation was a sincere and strong expression of concern by Congress of the severe problems of alcohol and drug abuse among our Indian people. This legislation focused attention on the problems of alcohol and substance abuse, provided resources to address the problems, and mandated coordination of efforts by the Bureau of Indian Affairs, the Indian Health Service, and the tribes themselves to expeditiously and more effectively utilize resources.

For the tribes, the legislation meant that additional resources and assistance—although limited—was available to begin alleviating the major health and social problems that plague our Indian communities.

In the Phoenix area a joint committee was established to oversee the implementation of the alcohol and substance abuse legislation. Representatives from the Indian Health Service at Phoenix and Tucson, the Bureau of Indian Affairs in the Phoenix area, and two tribal leaders each from the States of Nevada, Utah and Arizona served on the committee. The committee met regularly when the legislation was first passed, and the committee submitted a proposal for a regional youth treatment center for the Phoenix area to Dr. Rhoades.

Congress, through the law, appropriated new resources for training, treatment and aftercare services, and construction and renovation of facilities. There was great anticipation and expectation by tribes that these resources would be immediately available to the service units, to the schools, and to themselves; however, in the Phoenix area this did not occur. The Administration's Office of Management and Budget held up the release of the funds to the Indian Health Service until June of 1987. The Indian Health Service then took time to develop distribution formulas and funds were not available to these areas until July of 1987. The Phoenix area, in turn, had to develop its own distribution formulas so that when the resources were finally divided up there was not enough time for the tribes that desired to contract for the funds and the programs to do so. In fact, for the Phoenix area a decision was apparently made not to provide aftercare resources to the tribes through "638' contracts.

In the end, the Phoenix area Indian Health Service decided to use the additional resources to relieve the deficit in their fiscal year 1987 hospital and clinics budget by identifying services provided that were related to alcohol and drug abuse throughout all of fiscal year 1987.

The law also provided for financial resources for the training of tribal and Federal personnel having responsibilities for drug- or alcohol abuse-related situations. The training funds were available to the Phoenix area by the end of June. The IHS Phoenix area made the funds available to tribes through "638" contracts. Very few tribes took advantage of these resources as the guidelines and criteria for the selection of trainers were restrictive and the time frame for submitting proposals was two weeks from the date the availability of the funds was announced.

An additional problem with the training effort by both the Indian Health Service and the Bureau of Indian Affairs was the severe lack of coordination, although the law specifically mandates that coordination of training be established through the tribal coordinating committee. Training schedules and dates conflicted, agenda topics at times were marginally useful, and usually tribal personnel were not aware of the training sessions at all.

The Tribal Coordinating Committee according to the law is to be responsible for scheduling Federal, tribal and other personnel for training in the prevention and treatment of alcohol and substance abuse. The Federal agencies need to provide directly to the tribes all information on training possibilities so that the tribes, service units and agencies can jointly plan the necessary training.

With regard to the Bureau of Indian Affairs for drug and alcohol prevention and treatment related efforts, the Bureau distributed its resources in a very restrictive manner. The Bureau identified only Bureau-funded schools as the recipients of most of its appropriated funds. Only 10 percent of the Indian children attend Bureau-funded schools. The resources for counseling, intervention and staff training were directed only to this small school population. Most Indian students attend public schools and at least 30 percent of the Indian youth in Arizona can be identified as dropouts. Given this situation, the Bureau could have planned the use of funds to the benefit of many more Indian youth. If additional funds are made available to the Bureau of Indian Affairs, the Bureau should plan with Indian tribes how best to target and reach Indian youth.

The law provided for the construction or renovation of a regional treatment center for youth in each of the Indian Health Service areas. Residential treatment facilities for Indian youth have not been available in the past. Therefore the possibility of having access to a resource raised great expectations and generated hope for Indian people. However, it was soon clear that the construction or renovation of 11 treatment centers, plus the cost of staffing for the centers, was impossible given the limited amount of funding available for the endeavor. If the Congress is truly committed to the establishment of regional treatment centers, then the funding for this effort must be increased. The need for such facilities is well-documented.

An additional problem exists within the law. The law provides that Federally-owned structures may be identified and used for residential or regional treatment centers for youth. In the Phoenix area a tribally-owned facility has been identified as appropriate for renovation for a residential treatment center. However, because of the language in the law that refers to a "Federally-owned structure" that would be suitable for renovation, Indian Health Service has determined that tribally-owned structures cannot be renovated. Clarifying language is needed that allows for tribally-owned structures to be renovated as long as the structure meets the required standards.

In conclusion, despite the implementation issues with Public Law 99-570, the legislation remains extremely important because it has focused attention and resources on the number one health and social problem affecting Indian people and Indian communities. The majority of the tribes in the Phoenix area have passed resolutions to establish their Tribal Action Plans as called for in the legislation and the development of Tribal Action Plans is proceeding.

The Phoenix area will again be submitting a proposal for a regional youth treatment center.

There needs to be continued improvement in the area of coordination between the Bureau of Indian Affairs, Indian Health Service, and tribes to further the intent of the act and to maximize resources. The Federal agencies must acknowledge the authority of tribes in designing service delivery systems to avoid issues such as those involved in the development of standards for programs. Such an issue was raised in the development of standards for child protection teams, which is explained in the attachment to my prepared statement.

As Indian governments we understand the need to reduce the overall Federal budget deficit. However, alcohol and substance abuse in the Indian community does need special attention and financial support. We, the tribes in the Phoenix area, commend Congress for focusing attention and resources on this problem and we are especially grateful for this committee's continued support of Indian tribes and people. We encourage and urge the committee to support continued funding to fully implement the Indian Alcohol and Substance Prevention and Treatment Act of 1986.

Mr. Chairman, that concludes my prepared statement. I would be happy to answer any questions, if need be. Thank you very much.

[Prepared statement of Mr. Antone appears in the appendix.]

Senator EVANS. Thank you, Mr. Antone.

Ms. Nadene Naff is next but I understand that she understood this part of the hearing would start at 3:30, so she will probably come in a little later and we will add her to the next panel.

So next is Mr. Wisdom Nibbs.

STATEMENT OF WISDOM NIBBS, JR., CHAIRMAN, CHEYENNE-ARAPAHO BUSINESS COMMITTEE, CONCHO, OK

Mr. NIBBS. Thank you very much, Mr. Chairman.

Mr. Chairman, I bring you greetings from the Federally-recognized tribes of Oklahoma and Kansas. My name is Wisdom Nibbs, Jr. I am Chairman of the Cheyenne and Arapaho Tribes of Oklahoma. I have submitted written testimony as required; however, my statements at this time differ somewhat from my written statement and are additional. I would ask the Chair and this committee to enter these comments as part of the record.

Senator EVANS. Indeed, they will be.

Mr. NIBBS. Thank you for this opportunity to comment on initial year results of the attempts to implement Public Law 99-570, the Anti-Drug Abuse Act of 1986.

The timeliness of this call for comments and recommendations indicates to me that we are seriously concerned that the programs and projects in Public Law 99-570 work efficiently and effectively. In this regard I wish to emphasize that the reason I speak to the issues of efficiency and effectiveness is primarily for the establishment and operation of programs with such qualities, or to assure that existing programs acquire such qualities.

The results are what Public Law 99-570 is about. In a mountain of agreements, plans, schedules, proposals, guidelines and reports that have been generated, we all need to refocus periodically on the results and benefits which are anticipated. Through education, treatment and care we are going to correct and prevent substance abuse.

The results of our efforts in pursuit of these goals are not going to be immediately measurable. It may be more in truth to say that all the aforementioned agreements, plans, etc. have done nothing but delay these same results.

I have no report for you on any program implementation or project started in my area. The Cheyenne and Arapaho Tribes have received some additional nonrecurring funds for the alcoholism program. These funds were available for use beginning October 1 of this year. To what degree this modest increase in funding will impact overall on the tremendous problem of alcohol abuse in our service area, I hesitate to guess.

In addition to the usual protracted effort of the educational process, several factors contribute to this delayed knowledge. However, a good many of these factors are a product of procedural approaches that have been taken. Others are inherent in the design and plan for implementation. A few comments follow on some of the procedural problems encountered, as personally observed and as witnessed by other tribes from Oklahoma.

No. 1, lack of direction and vagueness of purpose on the part of the Bureau of Indian Affairs. It has often been difficult to elicit positive, specific responses from officials at levels of authority to questions or problems in the area of concern.

No. 2, lack of full funding for the legislation severely taxed the capabilities of tribes to implement effective, efficient actions and programs, and in some instances to develop a satisfactory Tribal Action Plan. This aspect, coupled with the fact that BIA's allotment of construction funds was not distributed to meet the purposes intended by the law, has critically limited the results of the initiative thus far.

No. 3, the nonrecurring funds for prevention that were made available to the Indian Health Service were barely significant for the various tribes in comparison to the magnitude of the problems experienced by many tribes throughout the Nation.

No. 4, the approach as set in action by Federal agencies in several service areas appears to be piecemeal and disjointed. The coordination between the BIA and the Indian Health Service has been ragged and slow in becoming useful, with considerable work in this area yet to be done.

No. 5, there has been a noticeable lack of information available that should have emanated from the memorandum of agreement between the two Secretaries. If such information was generated, to whom was it distributed, and when?

In view of the situation that has developed in our perception and experience since the inception of the legislation and in view of the pervasive and intensive need of tribal people and governments as we battle to control the problem it was meant to address, we respectfully recommend the following for the committee's consideration and deliberation.

No. 1, renewed emphasis on results at all levels within the appropriate Federal agencies.

No. 2, greater coordination among Federal and State agencies, especially with regard to education, prevention, and personnel training.

No. 3, development of all mandated regional treatment centers and creation of new, local, and easily accessible prevention and treatment centers.

No. 4, renewed funding of the legislation with increases of substantial quantity in the component sections to implement the programmatic approaches contained therein.

No. 5, increased emphasis on public awareness and research.

And No. 6, noncompetitive funding of programs demonstrating sound planning, approach, and commitment to address the problem at the basic level, with high priority given to total family intervention.

Mr. Chairman, I would like to add for the record that this was not available to me until I left Oklahoma yesterday. It's a letter addressed to me from the Chickasaw Nation of Oklahoma. I would also like to have this entered into the record.

Senator EVANS. Yes, it will be.

Mr. NIBBS. The letter reads:

> Dear Chairman Nibbs: We appreciate your letter informing us of your intention to testify at the Congressional oversight hearings concerning the implementation of the Indian Alcohol and Substance Abuse Prevention and Treatment Act, Public Law 99-570. A major concern we have is that these funds were only for a one-time distribution. Prevention activities should be an ongoing process in all alcohol/drug programs. Another concern we have is the slowness with which agencies, Indian Health Service and the Bureau of Indian Affairs, have responded in getting the funds to the tribes. Indian Health Service finally made an allocation of funds late in the year and then only for a small amount. The Bureau of Indian Affairs has placed a freeze on construction funds and can't seem to give any information to the tribes. Unless some policy can be mandated to ensure that tribal needs are addressed in a timely manner it will remain, once again, our people who suffer the consequences.

It is signed by Bill Anoatubby, Governor, Chickasaw Nation.

Mr. Chairman, that concludes my statement.

[Prepared statement of Mr. Nibbs and the letter from the Governor, Chickasaw Nation, appears in the appendix.]

Senator EVANS. Fine. Thank you very much, Mr. Nibbs.

The final member of our panel is Ms. Katherine Arviso.

STATEMENT OF KATHERINE ARVISO, DIRECTOR, DIVISION OF HEALTH IMPROVEMENT SERVICES, NAVAJO NATION, WINDOW ROCK, AZ

Ms. ARVISO. "Yah-te," which means hello in Navajo.

Thank you for the opportunity to speak before you this afternoon. My name is Katherine Arviso, and I am Executive Director for the Navajo Division of Health. My testimony before you this afternoon concerns the opportunities and problems which we, the Navajo Tribe, have experienced in implementing Public Law 99-570.

The Navajo Tribe was fully informed of the act by February 1987, and responded to the prototype memorandum of agreement between the Departments of the Interior and Health and Human Services. From there, the Tribal Chairman's office convened a Strategic Work Group which consisted of different tribal staff delegated by their respective directors, IHS representatives, BIA representatives, and officials from the Navajo Health Systems Agency. This group was to, one, compile information on the extent of the substance abuse problem; two, determine available resources; three, draft a Tribal Action Plan; and four, inform tribal executive offices and community leaders of the tribal effort.

As of this date, a Tribal Action Plan has finally been submitted to the Navajo Tribal Council for ratification. As required by the act, the plan contains a description of the extent of the problem, available resources, goals for addressing the problems, and a brief overview of issues relating to implementation. It does not, however, outline the means of implementing the act itself, and the reasons include, one, organizational problems within the tribe when the present Administration took office; two, problems in relationship with the Federal Government in drafting this plan; three, wider-ranging problems in data base management and planning; and four, noncoordination with State activities.

The tribal bureaucracy was not really prepared to take the lead in implementing this act. In an effort to curtail the bureaucratic entanglement, the Chairman's office delegated the Division of Health as the lead agency in coordinating tribal, Bureau and IHS efforts. Because the Navajo reservation constitutes an IHS service area, they began initiating their own plans. Many of them felt that it was better to coordinate at the service unit level, and then deal directly with the appropriate Federal offices, thereby bypassing the tribal coordination efforts. As a result, many of the service units and surrounding communities drew together uncoordinated plans, each of which advocated the location of a residential treatment center within their respective communities. Also, tribal departments, such as education, social welfare and public safety are funded primarily through Public Law 93-638 contracts and grants with the Bureau of Indian Affairs, while the Health Division deals with IHS. There was thus a tendency for all the different departments to be pulled strongly together with their respective Federal contracting agencies rather than within the tribe. This was not discouraged by the IHS and the BIA.

Problems also involved, one, apparent lack of coordination within the BIA and IHS; two, a lack of technical assistance; and three, unilateral acts in which the tribes' input was ignored.

COORDINATION

Much of the help provided by IHS was not coordinated through the tribal offices. IHS helped individual tribal members, but not openly. As a result, factions—both within the tribe and IHS—tended to disagree with the content of the Tribal Action Plan.

A strong form of paternalism could be seen in the ways in which Federal officials provided technical assistance. The IHS and the BIA tended to foster a form of neurotic dependency on the tribal members as individuals. First, Federal staff took a largely passive role at planning meetings. They would later, outside formal decisionmaking meetings, approach individuals in charge of writing certain parts of the plan, assure the individuals that the tribal staff were drafting the plan all wrong, and then offer to do the writing for them. Second, when tribal staff who took strong stands on self-determination took the initiative in organizing tribal efforts, the Federal staff would boycott and in other ways undercut tribal leadership.

TECHNICAL ASSISTANCE

When Tribal Action Plan drafts were completed, IHS officially or unofficially maintained that the particular draft was inadequate. They failed, however, to explain their reasons. This pattern of input had two unfortunate effects. On the local level, it meant that different factions and subgroups tended, at any one time, to work on the Tribal Action Plan. On the national level, it meant that a proposal for a regional treatment center was never completed adequately for favorable consideration.

UNILATERAL DECISIONS

It was not until early September that the tribe, BIA and IHS managed to agree on who was to do the work and how it was to be done. The result was a "committee document" which contributed nothing to actual implementation of the act. Both the BIA and IHS, meanwhile, proposed their own plans for spending that they were receiving and of which the tribe was informed only at the last minute. The tribe, upon review of these plans, submitted its own counterproposal in line with the final Tribal Action Plan. These were ignored, and over one-third of the funds for youth substance abuse treatment and prevention were taken by IHS for its own purposes.

IHS attempted to explain that it planned to fund these positions through its own system once the act came to an end. This means that existing funding after the end of the Omnibus Drug Act will be at the expense of the tribal programs presently funded by IHS through Public Law 93-638 grants and contracts.

CONCLUSION

The Navajo Nation wishes to emphasize the need for increased efficiency in the use of every available Federal dollar in support of Public Law 99-570. Unless we are allowed to participate as an equal partner in the implementation of the act, we foresee very little success in addressing the problem of substance abuse on Indian lands. Should this occur, we, the Federal Government, and the State government will have instituted another Government program benefitting only the Federal bureaucracies.

We, the Navajo Nation, believe the abuse of alcohol among our people to be the number one health problem in the Navajo Nation. Therefore, we believe we can ill afford another Federal experiment in Indian country. Public Law 99-570 should not be just another experiment. Given the extensive public attention to the drug abuse problem which propelled Congress to enact this law, expectations are high. For this and other reasons it is especially important for this program to overcome the confusion and false starts we have experienced this past year. We are only asking that we be allowed to do for ourselves what others have failed so miserably to do for us.

Indians have the right to be involved in decisions which directly affect their lives. We urge that our stated concerns be incorporated into any changes this committee may recommend for Public Law 99-570.

Mr. Chairman, given the limited time we all have today, I will end my remarks here. The written statements we have submitted for the record include a recommendation for improving the implementation of the Omnibus Drug Act in Indian lands.

Mr. Chairman, I have a copy of the Navajo Tribal Action Plan for your committee's information and review. Thank you for allowing me to appear before you today.

[Prepared statement of Ms. Arviso and the Navajo Tribal Action Plan appears in the appendix:]

Senator EVANS. Thank you very much.

Let me go back. Mr. Lone Fight, I had an opportunity to look at the supplement you gave to us and I find the figures really startling. The adjusted death rate for alcoholism that you mention on the Fort Berthold Indian Reservation is 200.6 per 100,000 population compared to a 6.4 rate for the entire United States population. That's a rate 30 times as high as the average population. That's followed by other very similar statistics that you have. That is really a striking problem. Is that of long standing? Is it primarily a problem of alcoholism or is it matched now by problems of drug abuse? Do you have similar statistics on deaths or illnesses regarding drug abuse?

Mr. LONE FIGHT. Thank you for the question, Mr. Chairman. This data which we provided was not generated just by our own self interest in respect of providing a kind of a portrait of our conditions on Fort Berthold, but rather they were developed by various independent studies.

The first report that you mentioned was developed under what they call a Joint Tribal Advisory Commission study, normally referred to as JTAC. That study revealed the data that you mentioned. The other data was revealed by the study done by ORBIS, which is also another independent organization that provides studies on our reservation.

So yes, these are very startling data, and I think the public law attempts to do something about the problems that we have. More recently, I think drugs have appeared on Fort Berthold as well as many other Indian reservations.

Senator EVANS. At this point, recognizing—I get some of the same feeling from each of the panel that difficulties have arisen, which I suppose would be expected under any new act, but they seem to be fairly consistent in terms of problems of coordination and priority-setting and of involvement of tribal leadership in developing these plans. If you had your own opportunity to just set priorities with a new program and with money associated with it, what in your view would be the top priorities? What kind is it? Are they in-resident treatment centers? Are they education programs? What do you think at this moment would be the most significant kinds of treatment or action?

Mr. LONE FIGHT. I thank you for the question. I'm going to refer that to Sue Paulson, our Chairman of the Tribal Action Plan Committee. She has developed with the committee a series of reports. I'll refer that to Susan.

Senator EVANS. Surely.

Ms. PAULSON. Thank you. In answer to the previous question that you asked our Chairman here, since the Garrison Dam—and I'd like to emphasize this—the mental health of the Three Affiliated Tribes has really deteriorated. It's about as old as I am, which is maybe about 35 years since we've been moved from the bottomlands, and I think the move and all the things that have happened and the division of the communities into the way that we're divided now has really caused a lot of problems with our people.

Senator EVANS. Can you explain a little further, at least for this Senator? I've not had the privilege of visiting that reservation, but once the Garrison Dam was built—was the entire tribe, prior to that, in a fairly cohesive or natural location?

Ms. PAULSON. Yes, they were. Eighty percent of the population was moved, and they had a choice of what segment they wanted to move to. They were moved to the toplands. And when the older people testified to the JTAC, they said, "We were moved to the hills." Our habitat has always been for centuries along the bottomlands of the river and our ecosystem was destroyed. So with that I think you have to realize that this has really been devastating and it's very, very recent, and I think that's reflected in our statistics. We have——

Senator EVANS. When you said "their choice," did the tribe then split into different communities?

Ms. PAULSON. Well, we had no choice. We had to move. They gave us the communities and they said, "Well, which one do you want to live in," more or less.

Senator EVANS. That ended up with the tribe split into a variety of——

Ms. PAULSON. Yes. And the transportation and—say, for instance, the farthest community from our central headquarters is about 200 miles. We can't serve this community. This community is a community of about 350 people, maybe, and they have no services.

We have testified before Congress before, because—for instance, in Indian Health Service, we only have two FTE doctors, and we used to have to fly them to this community of Twin Buttes. We are suffering with the same problem with Public Law 99-570 in implementation. How are we going to meet the needs of these communities? They are so far away, and our population is maybe 3,400. With the way that our resource allocation criteria—OK, you've only got 3,400 people, so here's your little $64,000, and go for it. I mean, we're ready to combat alcoholism but we're standing on the line without any ammunition.

Senator EVANS. What about priorities? Given the nature of the communities as they now exist with this extraordinarily high rate of alcoholism and its effect on survival at birth, what is in your view the most important priority? What should we be focusing on?

Ms. PAULSON. OK. This is just my own estimation, but I would say that 80 to 85 percent of the families—and I'm talking families, because you can't look at individuals in the disease of alcoholism; you have to look at the families—about 85 percent of our whole population is affect by alcoholism. Prevention, to me, is treatment. There is no way that we can just have prevention programs in the schools because what are we going to prevent the disease of alcoholism with? Because those kids have to go home at night. And we've had kids saying, "I don't want to go home at night. Where am I going to go? I can't sleep." It's really tragic and terrible and it's going to take a big, big effort, way more than what we've got. Like I said, $60,000—how are we going to divide that and help our population?

We need inpatient treatment. Inpatient treatment to me is prevention because you're talking about almost the whole population of the community. If we had inpatient treatment then the children would be involved in the treatment process and when their parents are sobering up, then they will have a chance. But other than that—we have no access to inpatient treatment. The regional treatment center to me is not the answer because we're still going to have to travel. We are culturally unique in the plains. We are very different from the Sioux and the United Sioux Tribes of South Dakota. All the resources tend to go to the same people, and I feel really strongly that we are culturally unique in the plains area. Our whole lifestyle is totally different. Unless we are given special consideration I am really afraid for us. I am bringing the concerns of the tribe because I am the tribal representative. I care about the other tribes and everything, but it's almost like the rich are getting richer and the poor are getting poorer because they say, well, what have you got that we can use to rehabilitate? And if you don't have anything then you're not looked as a center, or you're not looked at.

So Fort Berthold has the dubious distinction of having the highest mortality rate in alcoholism in the whole United States, and we probably have less resources because we are just floundering. I really feel strongly that we need inpatient treatment. If the JTAC recommendations—those being the Joint Tribal Advisory Committee recommendations—regarding the Garrison Dam—one of the promises that the U.S. Government made to the Three Affiliated Tribes was that they would replace the infrastructure, which was the hospital at Elbow Woods. The people are still in pain and still grieving because it's only been 35 years. If you talk to anyone they say, "We want our hospital back." If we had that hospital we would be able to develop a primary treatment and detoxification program for our people. I'm afraid that if nothing is done soon, I'm thinking of the whole deterioration of the culture. No one ever looked at us before they built that dam.

Senator EVANS. If at one time you had a hospital, however, which served a fairly——

Ms. PAULSON. Cohesive community?

Senator EVANS [continuing]. Cohesive community, how can you replace that now that the community itself is splintered?

Ms. PAULSON. It would still be closer than having to travel to a regional treatment center. It would work out better than if we have to travel a long ways.

In 1980 there was a study done concerning the feasibility of what we called a "long-term facility." We didn't call it a hospital; we called it a long-term facility. That was a really well-done study and it showed that that could be feasible.

Senator **Evans**. Are most of the Indian children in BIA or in public schools?

Mr. **Lone Fight**. About 50 percent, Mr. Chairman; 50 percent are in Bureau schools and 50 percent in public schools, but all located within the exterior boundaries of the reservation.

Senator **Evans**. Yes. To what degree are the public schools providing, through State resources or in other fashion, adequate drug or alcohol treatment programs for students generally?

Mr. **Lone Fight**. They do have some curriculum developed by the State under some of the Federal grant programs, such as Project Charlie and another one—I forget the name of it—"Here's Looking At You, Too," I think, which are used by the public schools. But it's not really coordinated with the tribe to meet the tribal needs and our tribal input. So maybe if some language was put into the act that would direct the local school districts to look to the tribal office for coordination purposes, that would better meet the needs as we see it.

Senator **Evans**. Because you would presumably want to have or at least suggest that the resources that might come through this special program would be available to students in public as well as BIA schools?

Mr. **Lone Fight**. That's our position on it.

Senator **Evans**. And that certainly would require coordination, then, if there were money coming from two different sources for essentially the same kind of program, or potentially the same kind of program?

Mr. **Lone Fight**. Right. Right now they have an 874 committee that's not really effective, in my opinion; also, a Johnson-O'Malley committee that's not too effective that works with the public schools. But I think if it really came from the act itself it would have a lot more teeth.

Senator **Evans**. Mr. Nibbs, in your case what appears to be the—we don't have quite the same statistical supplement, but are the problems just referred to and the difficulties of alcoholism essentially the same on your reservation or in your communities? Which is the larger of the two basic problems, drug abuse or alcoholism, among the youth?

Mr. **Nibbs**. Well, in Oklahoma, among the Indian people, I think the greatest problem is alcohol. We have only the younger people who are involved with the drug problem, but not in significant numbers. The public education system there does little to address the alcoholism and does a token effort, I think, in addressing the drug abuse problem.

You were talking about priorities earlier, Mr. Chairman——

Senator **Evans**. That was my next question. What would you recommend as the priority?

Mr. **Nibbs**. Well, it's obvious. In light of recent events, Mr. Chairman—I was just looking at a paper here that I received, a statement of the Assistant Secretary for Indian Affairs before the House Subcommittee on Interior and Related Agencies, dated October 27. It's been pointed out here today, I think, that the Bureau of Indian Affairs, to me, doesn't seem to have that much interest in this bill, in making it an effective bill. As a matter of fact, in here they're wanting to get out of the Indian business totally and just pare themselves down to three trust responsibilities.

It's been my experience, Mr. Chairman, that if you're going to make something effective, that you delegate either one agency or one person a responsibility and that way things get done. When you go to delegate authority to two or more people or agencies, the ineffectiveness is going to be what we have today. And I think that's what's wrong with this bill, is that—I understand the intent of Congress in trying to make the Bureau of Indian Affairs responsible in addressing the problem, but it's just that we're not getting that good a response out of the Bureau of Indian Affairs.

I would really recommend that this bill be changed to put your money into one pot, so to speak. Alcohol and drug abuse is a health problem, and I think that would be the agency more fitted to making an effective program of this bill, Mr. Chairman.

Senator EVANS. Just as something of an aside, is that, in your view, a fairly common problem that we end up sometimes with so many specified and separate programs that we use too much of our time and our effort in trying to respond to all the regulations of each program rather than kind of putting them all together and having a more comprehensive and more flexible program?

Mr. NIBBS. That seems to have been the problem, Mr. Chairman. That seems to have been the problem in the past. For instance, I'll give you an example. Once a bill is passed—in January of this year in Oklahoma, Mr. Joe Christy came down from Bureau of Indian Affairs and got with the Indian Health Service people in the area office there and held a meeting for all the tribes in Oklahoma and Kansas in regard to this bill. Mr. Christy got up there and made a three-minute introductory statement. And when he got through he said, "I've told you all I know about the bill." So that set the mood for the meeting for the rest of the day. We got no answers. The Bureau of Indian Affairs and the Indian Health Service did not know what funding, what their roles were, nothing. We spent a whole day there and didn't get any answers to our questions. As this thing developed further, it didn't get any better. The Indian Health Service, I think, made a concentrated effort to do their part and I think they were more effective; however, they were under the gun, too, in terms of the time period involved. They got the memorandum of agreement together; they caused many of the tribes to develop their Tribal Action Plans, but when it came down to the real purpose of the bill, and that is to address the prevention—the bottom line here, I guess, is dollars. We always talk about money to make things effective.

Well, for some reason or another they got delayed and it came around to September. And all of a sudden IHS said, "We've got to get the money out." So they used what they call "resource allocation methodology." In local areas they use a SURAM for a service unit, or ARAM for an area, and they just shotgunned the money out there. So everybody got a little piece of the action but not enough to really do any good, not enough to address the problem.

Senator EVANS. It seems to me from this and other hearings we may well be at a point where we're finding that we almost have too many programs aimed at too many small communities within reservations, and that by the time you splinter everything up and put as much money as ultimately becomes necessary just in the management and supervision and auditing and the rest of it, that you don't have enough left to really run cohesive programs.

Mr. NIBBS. That's correct.

Senator EVANS. It seems to me that in looking at this we may want to see how this interrelates, for instance, with other kinds of health problems and how we might give greater flexibility for tribes to design the kind of response to health problems that meets the particular needs and the geographic problems that go along with those needs.

Mr. NIBBS. Yes. The problem, I think, is four-phased. No. 1, you need to have an education program, of course, to educate those people who are not involved or the young people who may become involved. No. 2 is the treatment of those people who are already in that category. No. 3 is the detox, where you get to a point where a person just needs to go into a medical facility for those purposes. And after they're released from that, there is a follow-up.

Now, I think those four phases of the program are very necessary to addressing the whole problem. But what happens here, it seems like in this bill we target one area and forget about those other areas. I don't have a solution here today for that, Mr. Chairman, but I do see that as a problem.

Senator EVANS. Ms. Arviso, from your testimony I take it that you really didn't feel that you had the opportunity to participate from the beginning in designing and working with the BIA and others in carrying out this program?

Mr. NIBBS. That's correct, Mr. Chairman. Our problem was there, of course, again, the agencies involved didn't know their roles and were unable to give us any direction to help us, so to speak, so we were all just—pardon me?

Senator EVANS. I'm talking now to Ms. Arviso.

In your case was that essentially the same kind of problem?

Ms. ARVISO. Yes, the same. We just never got the groups together to really work on it. Yes, it was a real big problem, but we'd like to work closer together. We'd like a mandate having them work with us. They got some money, each group, and they're not sharing the information with us at all.

Senator EVANS. What would you consider the highest priority in this field? Again, among youth on the reservation, is it alcoholism or drug abuse? Obviously it's both, but is one a bigger priority than the other?

Ms. ARVISO. Yes. Alcoholism is the highest health problem, but the Health Division of our tribe does have a plan for the drug abuse part, so that is in our plan. The Education Department did put a plan together, yes, so we're ready.

Senator EVANS. Given the opportunity to establish a program, could you tell me what you think the highest priority or the most important thing that needs to be done is currently in terms of alcohol abuse for the young?

Ms. ARVISO. Yes. Number one is to develop an implementation plan. That is our number one goal right now. We do have a Tribal Action Plan that's going before the tribal council in two weeks, and

I've just hired a staff to begin the implementation plan. When that's done, we're ready to roll.

Senator EVANS. Mr. Antone, is this kind of a standard problem in the implementation of the act, in your view?

Mr. ANTONE. I believe so, Mr. Chairman. I would like to echo Chairman Nibbs' recommendations that the word "coordination" in the bill is something that we probably ought to recommend be looked at strongly. I think that was one of the efforts that took the longest time, to get the coordination going between the Bureau of Indian Affairs and the IHS and the tribes, trying to identify who had the lead role in moving it along. And I think that—if there were someone within the agencies or someone within the IHS or Bureau of Indian Affairs that was assigned specifically to work with the tribes on this, I think chances are we would be able to move a lot further than what we have done today. But in most cases the staff that we were assigned, especially in the Bureau of Indian Affairs, were somewhat at a lower status and therefore did not have the responsibility or the authority to make certain decisions that were called for in moving the dollars along.

But as far as the—again, I would have to agree with the panel here that I think emphasis ought to be placed on the preventive-type treatments, the educational approach. I think we need to get back into our schools to introduce ways and efforts to combat the situation that we're faced with. In Arizona, for instance, on my own reservation we're close to the border line and we have severe drug problems. It's gone to our grade school levels, and it's frightening to hear the children talk about the introduction of drugs within the school system. It is a real severe problem and that's why I believe the priorities ought to be toward the preventive-type educational programs.

Senator EVANS. In your community would you say the drug abuse problem is now as large as the alcohol problem?

Mr. ANTONE. It's fast becoming as large as the alcoholism problem. One of the problems we face is that none of our people, our counselors or staff people who deal with it, are trained to deal with drug problems. That is another reason that I think the training effort ought to be brought up in priorities. A lot of our people have been trained to deal with alcoholism. The approach in the past has been to identify a family lead, as one mentioned here. But I think it goes beyond that. The trend has been to deal with the disease, but once you deal with the disease you still have to deal with the individual, and that calls for professional types of counselling and approaches, and that costs dollars.

Senator EVANS. Thank you all very much. I'm going to have to scoot to get over and vote. We will recess temporarily, and as soon as Senator Daschle returns—which he will, I think, very shortly—and the Chairman, with this vote, if it is a satisfactory vote, I think the problem that he's had to deal with on the floor will be over and then the Chairman will be able to join us.

But I would ask that Ms. Nadene Naff, Ms. Jo Ann Kauffman, Mr. Kenneth Charlie, and Mr. John Blackhawk be prepared as the next panel as soon as we reconvene.

[Recess.]

Senator Daschle [acting chairman]. The committee will come to order. We will now invite the second panel to come before the committee: Ms. Nadene Naff, Ms. Jo Ann Kauffman, Mr. Kenneth B. Charlie, and Mr. John Blackhawk. If those four individuals could come before the committee at this time we will take their testimony.

It appears we're missing one individual. Could you identify yourselves so I'll know who we are missing?

Ms. KAUFFMAN. I'm Jo Ann Kauffman.

Mr. CHARLIE. Ken Charlie, here.

Senator DASCHLE. Nadene obviously isn't here.

We are delighted that you are here before us this afternoon and we will take your testimony at this time. Why don't we start with Jo Ann?

STATEMENT OF JO ANN KAUFFMAN, DIRECTOR, SEATTLE INDIAN HEALTH BOARD, SEATTLE, WA, REPRESENTING THE AMERICAN INDIAN HEALTH CARE ASSOCIATION

Ms. KAUFFMAN. OK. Thank you, Mr. Chairman.

I am here before this committee to talk about alcoholism and alcohol abuse as it is affecting American Indian and Alaskan Native people across the country, but in particular for those populations who live off reservations in urban areas. I am here representing both the Seattle Indian Health Board and the American Indian Health Care Association.

First of all I would like to say congratulations to this body and to all the tribes who have undertaken the important task of dealing with alcoholism. The effect of alcoholism is the most critical single issue facing Indian people today. How we deal with this issue will indicate how successful we are in all other aspects of our wellbeing.

The Seattle Indian Health Board was incorporated in 1970 primarily to provide health services and related services to Indians in the greater Seattle area.

The Federal Government, in the 1950's and 1960's, relocated hundreds of thousands of Indian people away from reservations and into some of the larger urban areas in the United States. It is estimated that 50 percent, or half a million, of the Indian people in the United States reside in urban areas. In Seattle, for example, the birthplace of the phrase "Skid Road," it is estimated by the city that 20 percent of all of what they refer to as "public inebriates" on Skid Road are American Indian. This is grossly out of proportion to the number of Indian people in the total population of that area.

In 1972, our organization began providing alcoholism treatment through special funding from the National Institute on Alcohol Abuse and Alcoholism. In 1976, because of Public Law 94-437, the Indian Health Care Improvement Act, our alcoholism treatment program was transferred from NIAAA to the Indian Health Service, as were all the other Indian NIAAA programs. Since then we have enjoyed a very good relationship with the Indian Health Service and with all the tribes in the Pacific Northwest and many of the villages in Alaska. We provide inpatient alcoholism treatment for the Indian people in Seattle and throughout those reservation areas.

In 1986, out of the 46-bed facility, 70 percent of our beds were filled all the time, and we provided alcoholism treatment to people who represented 64 different tribes. Today we operate a 95-bed facility and can provide inpatient alcohol treatment to male, female and adolescent clients.

In a study that was done by Dr. Dale Walker, a researcher in Indian alcoholism, it was found that over 54 percent of all the adults 18 and over are actively involved in the progression of alcoholism. We have further studied the results of alcoholism for family members who are living with alcoholics. In a special national demonstration program, to look at children of alcoholics, working with the 10 tribes in Puget Sound, we found that 80 percent of all adults have grown up in alcoholic homes, and it is estimated that that number or higher is the experience of little children today who are growing up in alcoholic environments.

The problem of alcoholism for Indian people is a systemic, community-wide, intergenerational problem; that is, it is all around us. It is in our leadership; it is in our environment, and it has become our relative. To prevent alcoholism we have to "break the cycle" of this intergenerational disease. That means more than simply treating the alcoholic, although I assure you that there is not adequate resources today to treat individual alcoholics, and I support all of the statements that have been made before to ask for more treatment dollars for adults and more treatment dollars for adolescents for those people who are experiencing alcoholism. But we are also finding that children of alcoholics are at much higher risk of becoming alcoholics themselves, and children of alcoholics are at higher risk for being abused sexually, physically and emotionally. Also, children of alcoholics are much more likely to grow up alcoholic, to tolerate alcoholism and to enable alcoholism among others in their environment.

What we are asking, upon reviewing the implementation of Public Law 99-570, is that corrective language be added to either Public Law 99-570 or the Indian Health Care Improvement Act, whichever would be easiest to accomplish, which would allow for urban Indian populations to be eligible to develop alcoholism treatment services through the assistance of the Indian Health Service to serve those Indians in urban areas with alcoholism problems. We would also ask that this committee instruct the Indian Health Service to examine Indian alcoholism treatment centers which are accredited and certified, and to utilize those when possible for treating Indian alcoholism and to reimburse those treatment centers at a rate comparable to what they're willing to reimburse non-Indian treatment centers, or at least at a rate comparable to the cost of providing the services.

In the Portland area there is a proposal by the Portland Indian Health Service to reimburse for adolescent treatment, for example, at a rate of $50 per day, yet the Indian Health Service's own formula for measuring the cost of those services estimates that it costs $160 per day to provide that service.

We would also like to ask that this committee provide language in the Indian Health Care Improvement Act or in Public Law 99-

570, if amendments are forthcoming, that would provide special funding for the intervention and treatment of children and families of alcoholics. It is critical in order to break the cycle of alcoholism that these individuals receive special treatment.

Finally, we would ask this committee to recommend in the appropriation process for fiscal year 1989, that Title V programs serving urban Indian Health populations be encouraged and provided necessary funds to develop alcoholism treatment for that population.

In closing, I would like to simply echo the sentiments of those who have already spoken, that this funding cannot be a one-time effort. It has to be institutionalized within the Indian Health Service, within tribal communities and urban Indian communities, and the Bureau of Indian Affairs. The most difficult barrier facing the effectiveness of all of us dealing with alcoholism is to get past the level of denial. Alcoholism is a disease of denial, and one thing this legislation has done is to provide an opportunity for tribes to talk to each other and for Indian people to talk to each other about the real effects of alcoholism. On that level it has been an accomplishment.

Thank you.

[Prepared statement of Ms. Kauffman appears in the appendix.]

Senator DASCHLE. Thank you, Ms. Kauffman.

Ms. Naff.

STATEMENT OF NADENE NAFF, COUNCILPERSON, COLVILLE TRIBAL BUSINESS COUNCIL, NESPELEM, WA

Ms. NAFF. Thank you.

Mr. Chairman, my name is Nadene Naff. I am on the Business Council of the Colville Confederated Tribes. Today I am representing a consortium of seven tribes from the Pacific Northwest. They are the Nez Perce Tribe, Couer d'Alene Tribe, the Kalispel, the Kootenai, the Spokane, the Umatilla, and of course, the Colville Tribe. We want to thank you for allowing us to testify today.

The tribes represented here today are all located in the eastern region of Washington, Oregon and the western area of Idaho. Geographically, culturally and traditionally we are plateau tribes, and we commingle with one another.

I am going to leave my written statement now, if I may, and I'd like to be assured that the whole written statement is entered into the record.

Senator DASCHLE. Without objection it will be inserted in its entirety.

Ms. NAFF. It seems redundant because so many of the things that we have said have already been said here, and it's repetitious.

At the moment I would like to direct you to the exhibits that I submitted with our statement, and I'd like you to refer to that so that you could have an understanding of what we're talking about when I mention the fact of why the consortium formed, and that we are basically plateau Indians. You see the solid-colored stars on the left-hand side of the map. Those represent the treatment center facilities that are already in the States of Washington and Oregon. And just to the right of that you will see the Cascade mountain range goes through there, then the clear stars—those show you where the consortiums of tribes are located. And I am sure you can see, sir, that there's a considerable distance between where we are located and where the facilities are located.

Also, basically our culture, our traditions and our whole way of life are different in the eastern side of that portion of the country and the western side, so therefore we don't have the same philosophies, etc.

Also it is a tremendous distance and a hardship and we as a consortium feel that if we're going to approach this drug and alcohol problem, we are going to have to approach it from the full, whole, community/family aspect. Back in 1971 and 1972 when I was doing the first tribal alcohol program on our reservation I was treating a five-year-old alcoholic. That's how young our kids are affected. Our clinics now are telling us that we have babies born with alcohol and drug syndrome, and this is growing. It's becoming more prevalent all the time.

So we're going to have to go at this problem totally. And the first thing we have to do as tribes—and now I'd like to direct you to the last page of the exhibits that I brought with me—last Friday we met in Spokane, all seven tribes, and we did a little questionnaire. You will notice that only two of those tribes have any kind of a juvenile code whatsoever. We feel that to get at the youth we're going to have to have, in our law, statutes which will allow us to do what we need to do. These are going to have to be approved by every tribal council and we're going to have to implement those codes. We do not—you will notice that there is not one juvenile detention center among those tribes. Any time that we have a juvenile—and by the time they get to this point in our area of where they're picked up, it's really, really bad. They are taken to adjacent counties, sometimes to metropolitan areas. We have one juvenile detention center in Okanogan County and one in Spokane, and that's where all of our children are taken—completely away from their families, completely away from their own culture, and they are put into non-Indian societies.

You will notice that we don't have local clinics on all our reservations. Also, we don't have adequate police departments. Not all of us have mental health. We don't have these resources that we're already supposed to have.

But the most important thing, skipping over to the far right-hand columns, the thing that we have today that we have not ever had in the past is that all of our communities within these tribes are totally supportive of our efforts for the first time. They're saying, "We've had enough. We want to help. We want to cooperate." Further, our tribal councils of all these tribes for the first time are ready to put the hammer down and say, "We can't live like this anymore. We've had enough. We're ready to pass this tribal code. We're ready to gear up. We're ready to say, 'All you resources that we do have, now you're going to work together and we're going to stamp out this problem.' " We're ready to say to our families, "No more. If you're not going to raise these babies properly we're going to take them and raise them for you, and we're going to raise them with the quality of life that they deserve, the opportunities in life that they deserve in today's society."

Getting back to the bill itself, one thing that has not been mentioned yet that I would like to bring out is that it mandates that you have to use existing Federal facilities that are already there. In our area there are no Federal facilities and we would like the bill amended to be flexible so that we could use other resources, other than Federal facilities—maybe build new ones, whatever we have to do. But the bill doesn't provide for that.

Another thing that I'd like to bring out is that the staffing that it calls for does not provide for elders or spiritual leaders or cultural leaders in the staffing and provides no salaries for those types of positions. The other thing that it doesn't call for is the training of our youth in prevention. We had hoped in our plan that our children that we do recover and do have out there would be able to help us get the others in. Just because they've been through it is not enough; they're going to have to have some kind of technical assistance also, and the bill does not provide for that.

In closing I'd like to thank you for your time and your attentiveness. Thank you.

[Prepared statement of Ms. Naff, with exhibits, appears in the appendix.]

Senator DASCHLE. You are welcome.

Mr. Blackhawk doesn't appear to be here.

Kenneth Charlie, please proceed.

STATEMENT OF KENNETH B. CHARLIE, CHAIRMAN, ALASKA NATIVE HEALTH BOARD AND MEMBER, THE TANANA CHIEFS CONFERENCE, ACCOMPANIED BY DENNIS P. DeGROSS, EXECUTIVE DIRECTOR, ALASKA NATIVE HEALTH BOARD

Mr. CHARLIE. Thank you, Mr. Chairman and members of the committee. My name is Ken Charlie; I am Chairman of the Alaska Native Health Board, and I would like to thank you for this opportunity today to present this testimony before you on behalf of the Alaska Native Health Board and the Alaska Native people. I would also like at this time to introduce the Executive Director of our organization, Mr. Dennis P. DeGross. At the time when questions are permitted, I will direct the questions toward him.

In Alaska we have a very special interest in Public Law 99-570. The results of alcohol and drug abuse are very prevalent among our people in Alaska. Suicides, most of them alcohol-related, are very high among the Native population of our State. The national average is 12.5 per 100,000. Alaska villages experience 225 per 100,000, some as high as 750 per 100,000.

As an example, compare one small village of 230 population which last year lost three young men to suicide, to the city of Anchorage with a population of 230,000. In Anchorage, 3,000 young men would have had to commit suicide to match the rate of this small village. A catastrophe such as this would have compelled the attention of a shocked nation.

Criminal corrections is another area that brings up a striking example of the illness. Alaska Natives make up 17 percent of the population of the State. Our representation in correctional facilities is more than 40 percent. It is estimated that 95 percent of Native incarceration is connected to alcohol abuse.

Fetal Alcohol Syndrome, or FAS, is another example of a high rate in Alaska. The FAS rate in Seattle for all races is 1.7 per 1,000 live births. On the Navajo reservation it is 2.0 per 1,000 live births. In Alaska, the overall rate among the Native community is 4.2 per 1,000 live births, with some communities as high as 12 per 1,000 live births.

The final and most devastating example of how gravely the Alaska Native population is affected by alcohol abuse is found in the Alaska Native death rate from so-called accidents—snow machines, automobiles, boats, three-wheelers and gun discharges, to name a few. An estimated 85 to 95 percent of fatal injuries among the Native population involve alcohol abuse. This is approximately three times the national rate.

In my own village of Minto I have seen a family of seven that has been together for 11 years being broken apart by alcohol. There have been attempted suicides and a suicide that I have known of. I have witnessed other fatalities by auto, boat and fire that were alcohol related.

One problem with the implementation of Public Law 99-570 is the lack of clear coordinating authority. As an example, several Federal agencies were given a piece of the responsibility, but no one was given the role of leader. We would strongly recommend that IHS be given overall responsibility for administering Public Law 99-570. The process of implementation of Public Law 99-570 in Alaska has been in reverse order of Congressional intent. The law properly and appropriately focuses on the tribal community as the important action point for direction, planning and implementation of treatment and prevention programs. Alaskan tribes or villages were not notified by BIA or IHS in a timely manner of the opportunities available to them for development of Tribal Action Plans, or TAP's, nor was the tribal planning process adequately funded. In Alaska, where 196 eligible tribal units must come up with Tribal Action Plans and where there is very little experience in health planning, the $258,600 that was available is simply not enough to do the job.

Funds to support Tribal Action Plan efforts were the last to be distributed after decisions had already been made as to how the program funds would be spent and by whom. This leads to the actual experience in implementing the law that indicates poor coordination between BIA and the Indian Health Service at the national level, including the imposition of impossible time frames for the development of these plans by the villagers.

We make these recommendations.

One, that the tribal planning process be adequately funded.

Two, that BIA and IHS be directed not to cast their programs in concrete until tribes are allowed to flow up through the Tribal Action Plan process.

Another problem with the law is that it tends to be single issue-oriented. Alcohol and drug abuse have multiple problems that should also be addressed. As an example, vocational rehabilitation or improvement of desperate economic conditions underlie many of these problems.

In Alaska, the entire BIA involvement has been crippled because of the lesser presence of that agency there than in any other areas of the country. For example, there was no funding in Alaska for the tribal courts or the education aspects of the law. Far more Indians and Alaska Natives attend public schools than attend BIA schools, of which there are none in Alaska. The $2 million in education funds that were given back to the BIA for distribution to BIA and contract schools nationally should have gone to public schools with high concentrations of Indians and Alaska Natives.

Also, the halfway houses and emergency shelters that were treated in the law as so important simply did not receive adequate funding nationwide.

On the question of the construction of a youth treatment facility in Alaska, the amount established at IHS headquarters, $750,000, is totally inappropriate in terms of what it costs to do business in Alaska. Ideally, there would be a treatment facility in each of the 12 geographic regions of the State. However, yielding to reality, the collective tribes of Alaska have said that three treatment locations, situated in Sitka, Anchorage and Fairbanks, would function adequately. Resolutions from all of the 220-plus tribes there would be required.

The regional 638 contractor agencies, all of whom already have resolutions from their member tribes, feel this would be foolish and impossible to achieve.

A sure way to ensure that no youth treatment facility ever gets built in Alaska is to require that the applicant agency secure 220-plus tribal resolutions.

This concludes my testimony on behalf of the Alaska Natives. Thank you very much.

[Prepared statement of Mr. Charlie appears in the appendix.]

Senator DASCHLE. Thank you, Mr. Charlie, very much.

Mr. Chairman, do you have some questions?

The CHAIRMAN. No questions.

Senator DASCHLE. Senator Murkowski had indicated that he had some questions to ask of you, and I will ask them in his behalf.

In fiscal year 1987, the Indian Health Service distributed $136,000 in youth residential treatment funds to the Alaska area. How were these funds used in the Alaska area?

Mr. DEGROSS. Mr. Chairman, Denny DeGross.

The $136,000 will be used to purchase contract care for patients outside of the State of Alaska. Currently there are no treatment facilities inside of Alaska that would be adequate to do that job.

Senator DASCHLE. How do you view $750,000, which is the appropriate amount, to meet the treatment needs of the Alaska area? Is that suitable in your view?

Mr. DEGROSS. No, sir, it is not.

Senator DASCHLE. What do you estimate you'd have to have?

Mr. DEGROSS. We'd estimate a minimum of about $1.5 million to meet the needs.

Senator DASCHLE. So this is about 50 percent of what you feel you need?

Mr. DEGROSS. Yes, sir.

Senator DASCHLE. Have you worked with the other members of the board to develop a statewide treatment plan?

Mr. DEGROSS. We are in the process of doing that now. The Alaska Native Health Board is in a year-long process to develop—

to look at the whole system statewide and develop a plan of treatment and to make recommendations both to the Indian Health Service, Bureau of Indian Affairs and State of Alaska.

Senator **Daschle**. Can you give any specific examples of how a lack of clear coordinating autonomy among Federal agencies has resulted in implementation problems?

Mr. **DeGross**. Sir, we can't speak for the country as a whole, but in Alaska it has resulted in the fact that there are no Tribal Action Plans that have been written and accepted yet. There are no tribal coordinating committees that have been seated. There are no resolutions from the communities for the formation of the tribal coordinating committees that were stipulated in the law.

The Tribal Action Plan money that was finally made available by the BIA in August—this was 1987 money—for Alaska still has not really arrived in Alaska. At least, the last I had heard of anything happening up there this week, the money still had not gotten there, so there is no money that is in the State and that has been available. So nothing has happened. The Tribal Action Plan process which, under our understanding of the law, was to have been the foundation for programs that would be implemented through the Indian Health Service and through BIA simply has not been done. So the grass roots or the bottom-up approach has, in a very sad way, been controverted here.

Senator **Daschle**. Why do you recommend that Indian Health Service have the primary responsibility for this?

Mr. **DeGross**. Well, I think that—at least from our perspective—the Indian Health Service simply has more experience in this field than BIA. From the very beginning the BIA, at least in Alaska, has evidenced at best a lukewarm or a—not much enthusiasm for the program.

Senator **Daschle**. If I could ask Ms. Naff, the consortium efforts of the plateau Indians in the northwest States are examples of the kind of unity and cooperation that we're trying to address here. Is this a spirit of cooperation, a networking of resources, that should be exemplified in all parts of Indian country in the planning of human services and education and areas of economic development? How might we assist in supporting the kind of networking that you've addressed in your testimony?

Ms. **Naff**. Well, you might just go ahead and give us a blank check and let us be a model program to show everybody else how easy it's going to be.

Senator **Daschle**. How much do you want? Maybe we can give it to you this afternoon. [Laughter.]

Ms. **Naff**. How about a half a million dollars?

Senator **Daschle**. Half a million? I think we can handle that.

Ms. **Naff**. We'd really appreciate it, sir. [Laughter.]

We found in the consortium and in other tribes that we've talked with in our area that in Indian country we're going to have to stand united. We're going to have to work together, pool our resources and our problems.

Sir, we understand that there are constraints on money. We all have our problems. You know, I heard people talking the other day, worrying about 11 percent unemployment. The tribes that you're looking at there in that consortium range from 51 to 76 percent unemployment; yet this summer, when we asked for 1,000 cherry pickers, we got 15.

Senator **Daschle**. Why is that?

Ms. **Naff**. Part of the problem is the Department of Social and Health Services who penalizes these people if they earn a dollar. One family member goes out and earns a few bucks and they take it off their appropriation. The other problem is drugs and alcohol. It's a way of life that we have all turned our backs on for far too long. It's become accepted in Indian country, and it's not acceptable.

Senator **Daschle**. Could you just summarize for me, both of our witnesses—I assume that Ms. Kauffman had to leave, unless she's coming back—she had to leave? I understand.

Could you summarize for me just briefly—it's been a year now, just a little over a year since the bill was passed. Has there been any discernible change in the policies affecting the implementation of programs relating to drug abuse where you are as a result of this bill? If there has been a discernible change, what is the most perceptive difference that you've seen so far in the last year?

Ms. **Naff**. When the bill first came out we were all very excited and very enthusiastic. Here's our opportunity; now we can do something. Many of us have worked very, very hard. Many tribes have put their own resources in trying to get data together, statistics, to coordinate resources. We as a tribe got our TAP program in and we were told, "You have to resubmit this because you're not following the criteria." When we started putting that program together, they gave us a free hand—"the sky is the limit; you write it as you see it." There was no criteria, no written formula, nothing. And we put all that work into it and submitted it, and they tell us we've got to resubmit it with criteria, and we still don't have criteria. We have no idea what they want. I feel worse about this bill today than I did the day it was enacted. I don't know about anybody else. We're all getting depressed.

Senator **Daschle**. In other words, what you're saying is that not one thing has happened——

Ms. **Naff**. Not in our country.

Senator **Daschle** [continuing]. In the entire 12-month period of time since that bill was passed and it's just been tied up in red tape and a great deal of bureaucracy?

Ms. **Naff**. And no criteria.

Senator **Daschle**. How about you, Mr. Charlie?

Mr. **DeGross**. If I may, sir, there's been a tremendous buildup in expectation in Alaska as a result and a lot of enthusiasm generated out in the villages in very remote areas of the State. But the resources that were needed to carry that along simply died along the way and have yet to actually get out there.

Senator **Daschle**. Ms. Naff, do you disagree with that? I saw you shaking your head.

Ms. **Naff**. No, I don't. I'm just saying the same thing. We're in the same boat.

Senator **Daschle**. In other words—so what you're saying is that there are two problems. One is that the bureaucracy has just not been responsive to your specific needs; and two, even if it were responsive, there just hasn't been any kind of adequate funding for the kinds of plans that you had in mind?

Mr. CHARLIE. I might add that in a sense we are here to look at the problems that came about because of what has already been done. This, I feel, will greatly work toward solving the problems. I feel confident that what is being done today in this room will be a step toward an attempt that Congress makes.

Senator DASCHLE. Well, I hope we don't artificially raise expectations again. I hope so, too; that's why we're here, and obviously there is certainly an intent in the Congress, in this Senate, for making improvements and for making this system work.

One last question. I know there is another panel.

If you had to rate the program—I mean, it's a year old; you've had a chance to look at it; you've tried to implement it—if you were a school teacher and this program were a student, from A through F, what would you give it?

Ms. NAFF. An E.

Senator DASCHLE. For effort?

Ms. NAFF. Maybe.

Senator DASCHLE. That's being diplomatic.

Mr. Charlie.

Mr. CHARLIE. I don't know what I would give it. Maybe a D.

Senator DASCHLE. A D. Well, we hope we can impprove during the next semester.

Thank you both very much, all three of you, for your testimony. It was very helpful.

Mr. CHARLIE. Thank you.

The CHAIRMAN. I would like first of all to apologize for not being here at the outset. However, I am certain most of you are aware that I was managing a matter on the floor concerning the Iran-Contra hearings. I would like at this time to thank you, Mr. Chairman, for carrying on in my behalf. You have done a good job. I hope you can conclude today's hearings.

Senator DASCHLE. Thank you, Mr. Chairman. I don't deserve the accolades that Senator Evans does; he was the one who started the hearing this afternoon and has been here a great deal of time himself. But I'm very honored to have a role in the hearing and to be chairing it at this time.

Let's take panel three, Dr. Everett Rhoades, Mr. Ross Swimmer, and Mr. William Lennox. If the three could come before the committee at this time.

Obviously we don't have Mr. Ross Swimmer here, but perhaps our panel could identify themselves before the testimony begins, other than Dr. Rhoades.

Mr. LENNOX. William Lennox from Education.

Mr. CORWIN. Thomas Corwin, Director, Division of Elementary, Secondary and Vocational Analysis in the Budget Service at Education, accompanying Mr. Lennox.

Senator DASCHLE. Thomas Corwin.

Mr. CORWIN. Yes, sir.

Ms. ELBERT. Hazel Elbert, Bureau of Indian Affairs.

Senator DASCHLE. Thank you, panel members.

You've heard some testimony this afternoon from quite a diversity of witnesses who have attempted, in the last year, to work on this program. You have heard their criticisms. I just asked the last panel what they would grade this program, and one witness gave it an E and the other gave it a D, which is not exactly an overwhelming endorsement of the program as it exists. I would be interested in your comments in that regard, as well as your testimony. We will call on Dr. Rhoades first.

STATEMENT OF EVERETT RHOADES, M.D., DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY CRAIG VANDERWAGEN, M.D., DIRECTOR, DIVISION OF CLINICAL AND PREVENTIVE SERVICES, RUSSELL MASON, CHIEF, ALCOHOL AND SUBSTANCE ABUSE PROGRAM; EVA MARIE SMITH, M.D., MEDICAL ADVISER FOR ALCOHOL AND SUBSTANCE ABUSE

Dr. RHOADES. Thank you very much, Mr. Chairman and other members of the committee. I am Dr. Everett Rhoades, Director of the Indian Health Service. I am accompanied by Dr. Craig Vanderwagen, who is the Director, Division of Clinical and Preventive Services; Mr. Russell Mason, who is Chief, Alcohol and Substance Abuse Program for the Indian Health Service; Dr. Eva Marie Smith, a young Indian physician who has devoted her life to Indian health, particularly in the field of Indian alcoholism. I am not accompanied today by Ms. Phyllis Eddy, another Indian person who has dedicated her life to Indian alcoholism because Phyllis Eddy is working right now to implement this bill.

The latter three individuals I've named I'd like to present to the committee for accolades. These are the three individuals responsible for bringing about this monumental task that we are considering here.

I would also like, if I may be presumptuous, to have accolades to Senator Daschle who had started activities moving toward this very goal at least a few years before Congress brought this into fruition.

I have the usual prepared statement. I'd like to make just a few highlights from it and then I'd like to address some of the points that have been made here, all of which are very important and thought-provoking. And should I forget to give a score or a grade, I would like to suggest that perhaps the grading ought to begin with various elements. I would just point out that the budget process ordinarily does not furnish us the resources to carry out an activity like this until the first quarter of the year has gone by, as took place last year. As you understand, we're in a similar situation this year. I respectfully submit that that is a significant part of the difficulties that we have in bringing into creation something new.

Secondly, I would like to perhaps be the one individual here today to argue that the glass is half full instead of half empty. I think I can present some evidence that that is the case.

I would also like to respectfully remind the committee that current activities should be viewed in the context of one decade of activity beginning, as has been pointed out by other witnesses, with the transfer of responsibility for formal alcohol care from the National Institute of Alcohol and Alcohol Abuse, 1977–78, to the

Indian Health Service. There are now 217 of those programs that are active right now in addition to what is going on.

Alcoholism has been a major emphasis for the Indian Health Service since I have been Director and for a decade prior to that. I think it's important for contextual purposes as well to remind everyone that 15 years ago, when I was a member of the tribal council for my own tribe and attempted to get a group of Indian people to sit down and address the problem of alcoholism, it was not possible at that time even to address the problem which has been present in my tribe since at least 1868.

Viewed in that context I would like to submit that although we are far from even achieving our initial successes, a substantial foundation has been built that will put it within our hands. Particularly in the context of the excellent testimony offered by the representative from the northwestern United States, Ms. Naff, and that is that without that community dedication that she put forward so eloquently, no program can succeed. With that, we are going to succeed. We may not be able to succeed by the time the committee convenes again but we will succeed in our lifetimes in dealing with this very difficult problem.

Some activities that have been going on unrelated to Public Law 99-570 are a fetal alcohol syndrome prevention training project that has taken place at 68 sites across the United States, with a total participation of about 1,500 individuals between 1980 and 1985 using the "trainer of trainers," a concept that will multiply throughout all of the Indian country. The alcohol treatment guidance system, which has been criticized considerably, in fact is a model technique for telling us where we are, telling us where we have been, and telling us what we ought to do next. It is probably the single most important thing that will permit us to do something which I feel that I must emphasize over and over and over and which has not been sufficiently emphasized, I believe, that in the very last analysis the responsibility that falls upon the Indian Health Service for right or wrong, correctly or incorrectly, is to insist upon the quality of care that is provided. The problem is so great. The mission that we have to Indian people is so precious that we must not be satisfied with anything less than the best available.

In order to bring that about, one must plan carefully. One must discuss extensively. One must consult extensively, and then proceed at a judicious pace. Unfortunately, because of the magnitude of the problem, it is conveying perhaps the appearance of a greater degree of slowness than any of us would really like.

We have a training package for clinicians in the Indian Health Service. Five percent of the physicians—there are approximately 800 physicians in the Indian Health Service—have now been trained in dealing with alcoholism. That is a pitifully small number but it is a substantial beginning, and during this next year we are going to magnify that greatly.

It is important to keep in mind that out of 800 physicians, not all of those physicians are going to have the same attitude, understanding and dedication to alcoholism as they might to diabetes, gall bladder disease, heart disease, and so on and so forth. That represents a substantial undertaking. It cannot be achieved instantly and it cannot be achieved by a directive, but it will be done.

A major ongoing effort in the Indian Health Service is the integration of the alcohol programs into the overall Indian Health Service and tribal health care delivery systems. This is an absolutely vital activity. It's going to be very, very difficult to carry out. There are individuals in this room who remember the very, very anguished debates that took place in 1976, 1977 and 1978 about whether those alcohol problems even ought to come over from NIAAA to the Indian Health Service, to say nothing of incorporating them into the basic part of our program.

To some extent, perhaps as a result of the impetus brought about by this legislation, Secretary Bowen of the Department of Health and Human Services has established an interagency Indian alcohol preventive initiative. Although this is still in the formative stages it has begun to pay off already in that at least in one office represented in the Department of Health and Human Services there are now a disproportionate number of research activities being directed to Indian programs. That represents a substantial accomplishment as well.

I would just point out also in passing that there are eight provisions in this bill that we believe affect the Indian Health Service. These are, by and large, fairly complicated arrangements. It has been pointed out already, I believe, by some of the witnesses—at least expressed as a concern—that there may be a confusion of goals expressed in this bill; that is, is one of the goals to ensure the collaboration and cooperation of building some new team between the Indian Health Service and the BIA? Or is it in fact to eliminate alcoholism? It is my belief that that requirement that was placed in the bill by Congress is one of the most important provisions because even though at this moment in history it looks as if there is a diffusion of responsibility, it is just simply impossible for anyone, Indian Health Service or otherwise, to come along and say, "We're going to deal with alcoholism among youth without doing it with the Bureau of Indian Affairs." We've got to figure out a way that we can interface better. The burden is partly on the side of the Indian Health Service in relation to law enforcement. No one really knows all the answers that are demanded in that sort of activity.

So even if we did not want to do that, we cannot proceed without building whatever that relationship is with the BIA. Again, if one considers the time frame that has existed until today, I would submit that we have made major strides.

Another almost parenthetical observation. Just as in the passage of this piece of legislation, the passage of Public Law 94-437 that transferred those activities from NIAAA to Indian Health Service did not carry with them a single administrative provision. That is, the three people that I have named are responsible for all that activity, those 217 programs. We have done what we do in the Indian Health Service time after time after time. We say, "Mr. Health Professional in the area, guess what? In addition to those four other activities that you have, you are now the coordinator for the alcohol programs in this area." And with the exception of maybe one or two areas, that is a part-time responsibility in each of those areas.

Let me just remind the committee also that even though the statistics that exist are very, very frightening in their magnitude, there can be no question in my opinion of the fact that since 1973, when the mortality rate reached its peak, there has been a substantial decrease in the mortality of Indian people, corrected for age, associated with alcoholism to the degree of 50 percent. Let's say that that is 100 percent error in that because of challenge to the data. That means the trend line is still decreased by 25 percent. Something is being done right.

I do not propose—I think no one should propose—that that should be taken as evidence that all is being done that ought to be done. Quite the contrary. Perhaps the most important thing it indicates is that in fact the success is achievable.

I would like to call attention in closing to publications by the Indian Health Service made widely available. Perhaps the most comprehensive action plan for the prevention of alcoholism among Indians was put together by the Indian Health Service in 1985, long before this bill came available, and was distributed to every single tribe in this country. It was distributed to Congress, and we have a few copies available. Just this past month we have compiled the first comprehensive survey of school- and community-based prevention activities throughout the United States. Again, I won't go into the statistics that are shown here, but I would commend these to the use of the committee. Again, we have a few copies here.

When you look at this you realize that a great deal is being done. Thirty percent of Indian children—preschool age, for example—have the opportunity to participate in the BAES program, the Basic Alcohol Education Service. That represents an awful lot of Indian children. It also shows us that we can replicate that through the remaining 70 percent.

If I might close by anticipating a question from the committee. If I could perhaps summarize recitation of—as you pointed out, just over one year now has elapsed since President Reagan signed this bill. A series of meetings between myself and Mr. Swimmer in the Bureau of Indian Affairs was set up. As I recollect, the appropriation was finally passed somewhere in December of that year, following which I immediately sent out memoranda to the area directors of the Indian Health Service directing them and pointing out to them that briefing sessions were to begin with all due haste at that time with all of the tribes in the United States. These briefing sessions, which were available to every single tribe in the United States, took place between January and February of 1987. By March 16, a memorandum of agreement was signed between the Bureau of Indian Affairs and Secretary Bowen. Again, perhaps that was slow. If one considers the magnitude of some of the questions that were raised in jurisdiction and so forth, I believe that was a fairly significant achievement. That memorandum of agreement was published in the Federal Register on March 26. The Directory of Resources Available was completed in April. By May 11 we had worked out the question of emergency medical assessment. I might just pause a moment and point out that three little words, "emergency medical assessment," wham, let's get something done.

Let's build this emergency medical assessment. But think about it for a moment. What the law says is that the BIA policeman has got to do a medical assessment on each individual that comes into contact with him and make a medical judgment. That is something that must be discussed extensively. It must be studied extensively. It's got to be examined very carefully. That's a horrible responsibility to place upon a law enforcement officer, and we have yet to see exactly how it is going to work.

It is so easy to say, "Gosh, we'll pass this bill and we'll pass this policy," and suddenly people are going to stop drinking. That does not take into consideration the extraordinary fact that alcoholism in any population in the world is among the most entrenched, complicated activities that there are.

By May 18, the Indian Health Service had been apprised following the concerns about rescissions and sequesters and Gramm-Rudman and so on and so forth of the apportionment of our funds from the Office of Management and Budget by the end of May, prior to which we had to develop a spending plan for these activities.

By June 1 we had developed an allocation methodology which takes into account our best estimate of the greatest need as reflected either in pathology or in population. After considerable consultation with the tribes, training criteria had been developed for training all individuals concerned with alcoholism. By June 3, area intervention teams had been defined—they had not been completely established—again, working out a relationship with the BIA and the tribes and the Indian Health Service.

One of the more important and far-reaching provisions in the bill, not previously mentioned today, I believe, but perhaps it will stand as the greatest accomplishment is the provision of $500,000 for the model health promotion disease prevention projects which have now been awarded in a very short period of time. A great variety of activity has taken place, both on tribal programs and Indian Health Service programs, and it's going to have a pronounced effect on Indian communities.

We had to develop criteria for making judgments about the location of the regional treatment centers. Again, an activity not previously ever done by the Indian Health Service, and which required all sorts of planning and development. Even with that deadline and doing all of these other things, I would submit that the fact that there are now two regional treatment centers, achieved within a very short few months' time, is a considerable achievement. Maybe one might think in terms of a D-plus, C-minus; perhaps a little bit higher.

Two are not enough. More are going to be establised. We are going to find a way to do that.

The question of the release of additional staffing funds has now been made to areas—again, taking into account the best estimate of greatest need and so forth.

I could add other examples, Mr. Chairman, of the considerable achievements that have been made by the tribes. I would like, if I might again respectfully submit, that when the committee puts its report together, it talks with the tribes from the Albuquerque area who instantly came together, united, developed a plan, unanimously agreed to put a regional treatment plan at Acoma-Canoncito-Laguna, and that is one that is going. I think if one wants testimony, visible testimony of what can be done, it is there.

I would be very happy to try to answer any questions that the committee might have.

[Prepared statement of Dr. Rhoades appears in the appendix.]

Senator Daschle. Thank you, Dr. Rhoades.

Ms. Elbert.

STATEMENT OF HAZEL ELBERT, DEPUTY ASSISTANT SECRETARY FOR INDIAN AFFAIRS (TRIBAL SERVICES), DEPARTMENT OF THE INTERIOR

Ms. **Elbert**. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am pleased to be here today to discuss the implementation of the Indian portion of the Anti-Drug Abuse Act of 1986.

I, too, have a number of staff members here with me at the hearing who I would like to call upon to help with the answering of questions, if that's necessary. In fact, I have a number of them here because this is the first time the Bureau of Indian Affairs has been involved in a project of this magnitude, and especially addressing alcohol and drug abuse, so it required the involvement of a number of our programs in the BIA as well as in the Department.

I would like to submit my prepared statement for the record, which includes a detailed chart of the requirements of the law and the current status of implementation. Today I would just like to focus on a few of our efforts and accomplishments this first year and discuss where we believe this effort is going to take us in the future.

Subtitle C of Title IV of the Anti-Drug Abuse Act of 1986 is designated as the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986. As we began to implement this act, we acknowledged that substance abuse is an individual problem that could best be solved by the individual within the context of his or her own community.

I listened to Ms. Naff testifying this afternoon and I can't endorse what she said too much because I believe that the community very definitely has to be involved and really has to set the stage for how they are going to address the problem in the community. The kinds of things that Ms. Naff said today are the kinds of things that we said when we looked at the enormity of implementation that would be involved in this bill, and we did not feel that we would be able to even begin to put a dent in the problem, as far as the Bureau of Indian Affairs was concerned, if the tribes themselves and the people in the community were not involved and they didn't recognize that they had a problem and were willing to take responsibility for it and to address it.

Our operating philosophy is that problem-solving actions must come from local people who are helping themselves or others. We see the tribal governments as the primary agent to provide local assistance to the Tribal Action Plans. The BIA's role is one of facilitator; that is, information and technical assistance will be provided as requested to tribal governments as they develop and implement their individual plans.

The tribal response, we feel, has been commendable. I don't know how the tribes feel about this. As of October 23 of this year, a total of 280 tribes had passed tribal resolutions to develop Tribal Action Plans. In Alaska, four corporations and 17 villages have passed TAP resolutions. To date, 128 tribes and villages have completed a TAP and are now in the process of implementing their plan.

This law required the BIA and the Indian Health Service to do a number of things to assist tribes in dealing with their community problems of drug and alcohol abuse. I believe there has been some confusion regarding requirements of the law and BIA's role in this effort. Most of the requirements are to provide more information and better coordination among the existing Federal, State and tribal programs. The BIA is not in the position of determining how tribes should deal with the problem, nor are there funds available from the Bureau for general tribal use for alcohol programs.

Congress appropriated $22.5 million in fiscal year 1987 for BIA and gave specific directions on how to use the money. Although we reprogrammed $2.5 million of that amount, those funds were directed to specific areas. Funding for the implementation of the drug abuse law was not discretionary funding for the BIA, and I do not believe that many of the tribes understand the funding situation.

The Omnibus Drug Abuse Act provided us with the direction to focus on this enormous problem in Indian country. We believe that we have addressed all of the requirements of the law and have, in many instances, gone beyond our initial goal. We have established very good working relationships with IHS and have completed our memorandum of understanding and have established IHS and BIA coordinators and local Child Protection Teams to work with tribal counterparts and other Federal agencies to coordinate resources at the local level.

We have also completed our memorandum of understanding with the Department of Education and several interagency efforts are underway. We are working on an interagency effort for an American Indian-Alaska Native Youth Conference to be held in the spring of 1988, and we are participating on the Prevention, Education and High Risk Youth Subcommittees of the White House National Drug Policy Board.

Mr. Swimmer has also made a commitment to deal with the drug and alcohol abuse problem within our own agency. He has required that all supervisors attend training workshops focusing on alcohol and drug abuse in the workplace. He has also made a commitment to continue the efforts set in place during this past year.

To continue these efforts, we have outlined some areas of focus for the coming year. We plan to work with other Federal agencies to establish a data base and provide information monthly to all tribes and BIA and IHS offices, provide assistance to tribes to locate and access available resources to implement their TAP's, outline prevention actions that will be targeted to American Indian and Alaska youth populations such as the 1988 Youth Conference, work with the National Drug Policy Board to review and streamline existing programs, and institutionalize the BIA responsibility for employee sobriety and drug-free workplaces by establishing standard performance elements for managers that not only reflect individual requirements but also provide guidance in abuse situations through the application of meaningful employee assistance programs.

The problems of drug and alcohol abuse in Indian country are staggering but we believe that we are on the right track in assisting the tribes to focus on the problems in their communities and to develop appropriate plans to combat the problem.

Mr. Chairman, you asked for a grading of the effort that has taken place over the last year with regard to this act. I guess my feeling would be that a lot of progress has been made. I don't believe there is a single mandate in the act that the BIA and the Indian Health Service did not meet in a cooperative effort.

We are very pleased with what we were able to do in putting together the memorandum of understanding, the operation management plan, and we work daily on making sure that we carry out and meet all of those mandates.

As I said earlier, I believe there was some misunderstanding about the dollars that were there, that were available to the tribes, and we even asked that some of the dollars be reprogrammed that had been specifically designated for other things so that we could provide some dollars to the tribes to help them carry out or develop their TAP's.

There have been several questions raised from the tribes with regard to the facilities and with regard to the shelters that were mandated to be constructed under the act. One of the things that I find sort of troublesome as far as the monies for those two activities is concerned is that we don't have authority presently to use appropriated dollars to construct or renovate or whatever to tribal facilities. It would be helpful to the Indian tribes out there, I think, if some kind of authority could be given for us to do that kind of thing. It's something that has come up from the very beginning in trying to implement the act.

We have only been involved in implementing the act for a year, and Dr. Rhoades outlined for you all of the activities that have taken place in chronological order. I would have to say that the BIA was working right along with them on that same schedule. And really, I think it's too early to say how good we really have done. As far as the effort in implementing the plan, I think we did a very good job. If I had to give it a grade I would have to say we made an A on it because this is something that we have never been required to address before, and I think we did it in a very, very good manner.

One of the things that we have difficulty doing is meeting deadlines that are mandated in laws, 120 days, 130 days, and I would have to say that we had no idea—no hope—of ever meeting that deadline for publishing that MOA when we saw what the time frame was. When we got the dollars, when the act was given to us, we just thought that was an impossible time frame to meet. I think we only missed it by a couple of days, and we thought that was something that we should be commended for. And I do commend the staff for that.

Dr. Rhoades mentioned about three people that he had that had devoted quite a bit of time to implementing the act, and we have the same kind of situation in the BIA where we drew on certain people in the BIA and asked them to devote their time to making sure that the act was implemented, the mandates were carried out, as much information as possible could get to the tribes, and that we worked cooperatively with the Indian Health Service. This is a major undertaking when you consider that we had three different agencies involved here, and within the Bureau of Indian Affairs we had four programs in the Bureau of Indian Affairs and the Education Office, which is not necessarily within the structure of the BIA, so we had to coordinate within our own BIA as well as with the Indian Health Service and the Department of Education. I think we did a commendable job.

I would like to make sure that everybody knows that the Joe Christy that was mentioned by one of the tribal members, who went out and made his comments to the tribe, is one of the people who is responsible for making sure that we met all of those deadlines. We did go out with not an awful lot of knowledge about alcohol and drug abuse because it's not something that the Bureau of Indian Affairs has ever dealt with before. It is involved in all of our programs because we have a social services program, we have a law enforcement program, and we have a court system. But I don't think those are the programs that address those problems. They are programs that are involved in helping to address the problem, but we've never had dollars to do anything with regard to this kind of effort.

Some of the activities that Dr. Rhoades mentioned, the treatment centers—we have been involved in those as well. We have made sure that some of our funding went to help staff one of those facilities, and we are also working with the other facility as far as making sure that some of the property involved there is made available to the tribe so that they can carry out that program.

I guess I would have to say that we certainly appreciate the cooperation that we got from the Indian Health Service and the Department of Education, and we are available to continue to carry on this effort. There is a strong committment on the part of the employees in BIA to do something about the alcohol and drug abuse problem.

I think with that I am going to stop and be available for any questions that you would like to ask.

[Prepared statement of Ms. Elbert appears in the appendix.]

Senator **Daschle**. Thank you, Ms. Elbert.

Mr. Lennox.

STATEMENT OF WILLIAM LENNOX, DRUG ABUSE PREVENTION OVERSIGHT STAFF DIRECTOR, DEPARTMENT OF EDUCATION, ACCOMPANIED BY THOMAS M. CORWIN, DIRECTOR, DIVISION OF ELEMENTARY, SECONDARY AND VOCATIONAL ANALYSIS, OFFICE OF PLANNING, BUDGET AND EVALUATION

Mr. **Lennox**. Thank you, Mr. Chairman. I am pleased to be here to testify on the Department's efforts in implementing the Anti-Drug Abuse Act.

I am a special assistant to Secretary Bennett, and I am also the Director of the Drug Abuse Prevention Oversight Staff in his office. I mention that only to emphasize the importance with which he holds the Anti-Drug Abuse Act of 1986.

Last year the Department had one program at $3 million. This year we have 15 programs at $203 million. We are very proud of what we've done to implement this act.

I would like to submit my testimony and summarize, if I may.

Senator DASCHLE. Please. Without objection, your entire statement will be submitted for the record.

Mr. LENNOX. Secretary Bennett has been concerned about drug abuse in the schools since he became Secretary. One and a half years ago the Secretary charged a team of Department researchers with finding out what works in getting drugs out of schools. The result was "Schools Without Drugs," a handbook on establishing effective school prevention programs. The book contains the basic information needed to establish a comprehensive plan for schools: policies, resources, references, curricula information, model programs, facts about illegal drugs, but most of all, a plan—a plan broad enough that all communities can use it but specific enough in that it details who has to be involved. Its premise is that each community is different and each community must assess its own prevention needs, develop its own drug prevention program, and establish a means of monitoring it. The program, however, must be comprehensive, involving parents, school officials, law enforcement officers, community leaders and students. The validity of this approach is sustained in the research summarized in the "Report to Congress on the Nature and Effectiveness of Federal, State and Local Drug Prevention and Education Programs," submitted by the Departments of Education and HHS.

Following the guidance provided in "Schools Without Drugs," we have quickly mobilized the resources of the Department to assist schools and communities in the implementation of effective anti-drug programs. For the record, I have attached a summary of the Department of Education's programs. I would like to mention a few of these and explain how they will benefit Indian youth.

Besides the funds provided to States for their schools, the Drug-Free Schools and Communities Act authorizes the Department to provide funds to Indian children on reservations attending elementary and secondary schools operated by the Bureau of Indian Affairs. We have negotiated a memorandum of agreement with the BIA to administer the $1.9 million appropriated for this program. The Department of Education and BIA staff will jointly monitor these activities, which will provide additional opportunities for coordination between the two agencies.

In our grant programs we made an effort to ensure that Indian schools were informed of our grants. As a result of these efforts a number of programs targeting Indian populations have been funded. Among the elementary and secondary school projects, the Red Cliff Band of Lake Superior Chippewas, the University of New Mexico, Red School House, Inc., and the Fort Belknap Community Council were award winners. In higher education, the University of Oklahoma, Standing Rock College, Pierce College, Salish Kootenai, and Cheyenne River Community Colleges won grants to work with

Indian elementary and secondary schools to form comprehensive programs.

Also in higher education two colleges, Oglala Lakota and Bacone, have also won grants to establish comprehensive programs on their campuses.

In addition to the grants the Department has also worked with a number of Indian schools in providing team training and technical assistance through the work of our five regional centers. We expect the centers to continue to provide training to public schools that enroll Indians.

These are some of the steps that we at the Department of Education have initiated to help stem the tide of drug use among the young.

While I have the opportunity I would also like to discuss our proposed amendments to the Anti-Drug Abuse Act of 1986. We believe these amendments include the elements essential to an effective Federal education policy to remove drugs from schools. They are meant to provide guidance, leadership and direction.

Among other things, our amendments would require school districts applying for funds to adhere to good management practices, to explain in their applications the drug problems in their schools as well as the policies, procedures and programs they will adopt to eliminate those problems. This may take care of some of the problems that were mentioned earlier where a school was merely implementing a curriculum without consulting the outside community.

In addition, the amendments would require districts to monitor regularly the effectiveness of their programs. In order to receive future funds, districts would have to show reasonable progress toward reducing their drug and alcohol problems or show that they have altered ineffective strategies. In short, our amendments would require assessment, institute accountability, and require either progress or change.

We are pleased that parts of these amendments have been incorporated into H.R. 5, the Omnibus Elementary and Secondary Education Reauthorization bill passed by the House. We are hoping for similar action from the Senate, but I believe that their inclusion in their entirety would be in the best interest of creating a forceful program for helping to remove drugs from schools.

We have learned a lot over the past year and a half about what works and what does not work in preventing student drug use. We know that the best hope for reducing student drug use is in comprehensive strategies at the local level. Many of the projects that I mentioned earlier that are specifically targeted for the Indian community include these essential elements. We look forward to evaluating their effectiveness as we proceed with monitoring efforts over the next year.

Thank you for the opportunity to address the committee. I would be happy to answer any questions.

I would like to make one comment. While we are only minor players in the sense of the $2 million, we do take our role very seriously and we have worked hard with BIA in implementing that program.

[The prepared statement of Mr. Lennox appears in the appendix.]

Senator Daschle. Thank you, Mr. Lennox.

Let me just ask a question of all three of you. We have had this program now for a year. If at the beginning of the year you had set some goals that you thought could be realized, if you could retrospectively consider those goals for a minute, do you think you would have realized those goals given the progress that you've just reported to this committee? Dr. Rhoades?

Dr. Rhoades. No, sir; we did not achieve those goals. In retrospect I am impressed with the progress that was made toward those goals.

My goal was to establish at least four regional treatment centers, for example. The process of doing that proved to be far more difficult than I had anticipated, somewhat naively, ahead of time. I would have had more people trained by now if I had met the goal that we had set, and we would have had in place better, I believe, what I regard as highly critical to the success of the activity. If I might parenthetically add also, I want to strongly endorse the testimony from the other witnesses that a single directed activity is insufficient. There is going to be a chain of events that is going to be necessary in order to deal with this problem. The disruption of any single link will make it almost impossible to do. But the intervention teams and the aftercare teams, we believe, are critical, and I would very much like to have had those in place further. I don't want to keep dwelling on this but I would just point out that eight months of the year had elapsed before we had the resources to really do those kinds of things.

Ms. Elbert. I support what Dr. Rhoades said because of the time frames that were involved here. But I guess I understood your question to be, if we had had a year to work on this, would we have realized our goals by now?

Senator Daschle. Well, that really wasn't my question. My question was if, at the beginning of the year, you had set out some goals that were legitimate goals, given the time frame within which you had to work and the resources, if you could retrospectively now set those goals do you think you could have met them, given what you have just reported as your progress before this committee?

Ms. Elbert. No. I guess I feel that our big goal was to be a facilitator to the tribes and to provide those tribes with all of the information that we could possibly provide them to help them address the problems that they have in their communities. And that's going out and meeting with each individual tribe out there and the communities and making them aware of what's available and what the problem is all about and how to recognize if there's a problem and to let them know, or to help them to understand and realize, that they have a responsibility there; and that unless they assume that responsibility and start doing something with it, that there isn't a heck of a lot that the BIA could do to sober up people, which I hope is the goal of everybody that's involved here, to get people sober at some point in their lifetime, get communities sober.

One of the witnesses talked about the high unemployment rate, and I guess all of that's a part of this goal that we're talking about when we address alcohol and substance abuse because we want to get those people so that they can understand that there is a different way of life out there and that the employment rate can be raised up.

I don't think we would have been able to get around to all of those tribes and I don't think we would be at a point now where we would have 100 percent of the tribes saying, "Here is the plan. We are in the process of operating it. We have taken responsibility for it and this is where we're going with it."

Senator DASCHLE. Mr. Lennox?

Mr. LENNOX. Part of my job, sir, is to set those goals. We did set them at the beginning. We have achieved them. The Department of Education has implemented this bill in an unbelievable fashion. We got the money out quickly, but we did provide assistance to people that needed it. That's not to say that this isn't a long-term problem. We'll continue working on it; the Department of Education is committed to that.

Senator DASCHLE. Perhaps with your success, then, you can cite for me one or two specific illustrations of the tangible effects of your progress.

Mr. CORWIN. While he looks up some exhibits, we are at a stage now where—well, let me start with the goals. The Secretary really had two goals. The first was to ensure that the $161 million that was made available to local programs, was flowing to the States by the time the school year began this September. We've done that. All the States have had their applications approved and the funds have been obligated. The funds are now going into the schools where the programs are beginning. I don't think at this point that we can point to reduction in alcohol or drug use yet because the program just began in September and October, but we have succeeded tremendously in getting the money out there so that the programs would begin this fall and not next fall, not in 1988.

The second goal was to get good programs going with the rest of the money, the discretionary grant money. Here, once again, the programs were funded over the course of the summer and fall and they are just getting underway.

Mr. Lennox will add to that.

Mr. LENNOX. Sir, I provided the staffs of most of the Members a copy of our goals, and I think they can judge how well we did against that.

I have here—we did a quick survey of some of the States. The money is in the States and it is moving to the local school districts. Arizona, for example, 212 eligible districts; the State has distributed its applications——

Senator DASCHLE. But my question is, Mr. Lennox—that's laudable, and I mean that sincerely. But what is happening within those school districts? What are they doing with the money? And what can you show me as some evidence that that money is really accomplishing what you've distributed it to do?

Mr. LENNOX. I can give you examples of programs that they're implementing. Is that——

Senator DASCHLE. That's what I'm looking for.

Mr. LENNOX. Arizona, in-service training for teachers; alternative programs; they're developing curricula; parent education; peer leadership.

You have to realize that there was a lot of lee-way in the law. We——

Senator **Daschle**. This just started? Now, you're talking about this fall?

Mr. **Lennox**. The money began being distributed in Arizona May 20. As soon as the bill was passed we started working on it. In December we sent out applications to the States. We sent out an invitation to a State conference. We held that conference in January. We discussed the regulations with which the bill would be implemented, and then began receiving applications in the month of February.

Senator **Daschle**. If I could go back, then, to Dr. Rhoades and Ms. Elbert, you indicated that you fell short of your goals this year. Do you think that, given what you know, given your current position, you will have the resources—and you now have the structural mechanism by which to attain whatever goals that you've now allowed yourself in the next 12 months?

Dr. **Rhoades**. I'm not sure. Let me ask you about the question, please, Mr. Chairman. I thought you were starting to ask, do we have the resources we need this year to reach the goals that we have set? And then you seem to have shifted. Given what we have now, will we be able to do more?

Senator **Daschle**. That's correct. Given the resources and given the progress that you said has taken this long to accomplish, do you anticipate that the goals that you'd like to set for the next 12 months will be far more realizable than the goals you set for this, the initial 10 months of this program?

Dr. **Rhoades**. Yes, sir. I believe I can answer that emphatically because I believe this year has been so largely taken up with building that foundation. And although that foundation isn't exactly just like we want it, it is a foundation. I can recite some more specifics, for example, that are underway right now, whether it's the Zuni Wellness Program or a team program at Shiprock, New Mexico, and so on and so forth. Those are now in place and they will start having results in the next year.

Senator **Daschle**. How many centers?

Dr. **Rhoades**. How many centers by the end of next year? I need to address that in the following way.

After examining the process that we went through in 1987 and studying what ought to be done in 1988, given the incredible diversity of areas of Indian culture and every other thing, some of which we've heard today, I have now received information from communities and from areas suggesting that in fact it may not be appropriate to construct an institution in some areas. In some areas—for example, the United Southeastern Tribes of this country in the eastern part of the United States—I think they clearly recognize somewhat the futility of a single place and have proposed that the services that would be available in such a facility be made available some other way using the same source of funds. And I believe that that is probably a very, very useful way to do it, and there will be other areas like that.

So I'm not prepared at this moment to put a number on the facilities that ought to be constructed, but I would say that my goal is to establish four more in the next fiscal year, but not neglecting in any sense those in which the tribes may decide that a structure is not what they want. We can begin providing those services to adolescent use by purchase from the private sector, for example, and we've already done so in the last quarter of this year.

So what I guess that I'm asking—and we will be coming to ask Congress to consider—a somewhat modified, expanded view of the construction of those centers.

Summarizing that, I believe a case can be made that the services could be as well provided, or perhaps better provided, in some areas without the building of a center. That's got to be worked and decided on and so forth.

Senator DASCHLE. Ms. Elbert?

Ms. ELBERT. Mr. Chairman, I guess I would say that the areas that we have decided to focus upon for this coming year, within the dollars that we have, we can achieve those goals. However, a lot of the effort that we have put in place up to this point is still ongoing, and there may be a number of areas where we'll have to step back and take a look and see if we need to go in a different direction or if there are other things that need to be done in addition to what's already out there. So it's difficult to say whether or not we would have enough dollars or manpower to carry out all of those requirements.

Senator DASCHLE. You were both in the room when Ms. Naff and Chairman Charlie indicated that they were quite frustrated and quite disenchanted, perhaps, with the bill as it is being implemented and the hope it holds out for addressing the issue. Do you feel that if we were to call them back a year from today, given your expectations and the goals that you have outlined, that they would come before the committee and then say, "Our problems have been addressed and we can say unequivocally that this program is a success"?

Ms. ELBERT. I don't think they will unless they fully understand the bill and the purposes of it and what——

Senator DASCHLE. Are you saying by that that they don't understand the bill, and that's the problem?

Ms. ELBERT. Well, I'm not saying they don't understand the bill. There were a lot of expectations out of that bill, and I touched on a few of them in my testimony. A lot of it just boils down to dollars. If the tribes don't get the dollars that they're expecting, it's always going to be that the BIA or the Indian Health Service didn't coordinate it right or didn't do something right.

If the tribes do as Ms. Naff says, accept that responsibility and see where they're going, I think that the things that we are doing in the BIA—they can come back and, if they're honest about it, they will say that they are satisfied with the way that we implemented the bill.

Dr. RHOADES. I wouldn't presume to anticipate what they might testify next year, but I would just point out that the frustration that has been expressed, I share completely. I don't think anybody has lost more sleep over this than I have, and I know that that's the case with Dr. Smith and her colleagues. I have asked her to go home at 11 o'clock at night because I needed her the next day. In fact, if one wanted to measure the sum total of frustration with this activity, it might exceed that for almost any other activity.

However, what I hear—and perhaps I'm looking for that pony, and I'm not ordinarily that kind of a person—but Ms. Naff gave a message of hope and excitement. Her tribe has engaged the problem. I think she understands—I hear a note of optimism in what she has said.

Now, I am willing to make the following assertion. We will be able to demonstrate a certain number of individuals who are sober at the end of next year compared with the beginning of next year. I do not know the size of that number but it will be measurable and be demonstrable. It might not be in those two particular communities, but we are going to see a decreased number of visits in our emergency rooms; in some places, 80 percent of those are associated with alcohol. We're going to see a decreased mortality rate from those other activities.

Now, is that success or not? Unfortunately, that is a judgment that rests in the eyes of the beholder that is going to be interpreted differently. I guess I would say that when a tribe comes somewhere and says, "We have now met the same goals that were met by the Alkali Lake community in British Columbia without any additional resources in that community," then that will be a success. It took them nearly 20 years.

The Indian Health Service goal is to raise the status of health of the Indian people. That will be measurably improved at the end of next year compared with the beginning of the year, I believe very, very firmly.

Senator Daschle. Dr. Rhoades, Ms. Elbert, Mr. Lennox, we want to thank you all for you—oh, excuse me, Mr. Chairman. Our most important questioner is yet to be heard from.

The Chairman. Thank you very much.

I've been told by many Indian leaders and Government leaders that there are more alcoholics per capita among American Indians than among any other ethnic group, nationality, or religious group. Is that correct?

Dr. Rhoades. Mr. Inouye, I'm not sure that's a true statement. But by saying that, I do not want in any way to minimize the magnitude of the problem. There is no doubt in my mind but that the mortality rate figures that have been reported for the Indians already today—my experience, now, in 30 years in medicine in the private sector and the Indian Health Service, is that an Indian who dies an alcohol-related death is many times more likely to be reported on a death certificate as an alcohol-related death than a non-Indian. I am very, very skeptical of the rates of alcoholism that are reported for the rest of the population. I don't know what fraction the statisticians may propose is underreported, but it is some.

I don't want to belittle the question, either. In my opinion, the magnitude of the problem is sufficiently great and the ramifications of it are sufficiently great that it really doesn't matter so much about the ratio between Indians and non-Indians and how much that is. It's the number one problem, and that means that we've got to direct more and more of our attention to it.

The Chairman. One of the leaders that I met suggested that 80 percent of the adult population of his reservation were alcoholics.

Dr. Rhoades. This is possible. And again, that was the experience that was related by Alkali Lake. I didn't hear that totally clearly; it may have been that 80 percent of the individuals on that reservation are touched in some way by the problem of alcoholism. But one would have to say that in certain small communities, that is a rate that may very well occur.

The **Chairman**. When this public law we are considering now was being debated in the committees, the suggested level for authorization was $99 million. I'm certain you remember that. And when this measure was passed by both houses and in conference, that number was reduced to $46 million. When it came time for the Appropriations Committee, $46 million was appropriated.

This year, $23,465,000 will be appropriated, which is a reduction of about $22 million. Would you be able to meet your goals that you have been discussing with that amount?

Dr. **Rhoades**. I might want to give some thought to that. I don't want to answer hastily, but I do believe that the infrastructure that is there would permit us to meet some of those goals. I would be happy to study that more thoroughly and make available an analysis to the committee, Senator.

The **Chairman**. Why was the request cut so low?

Dr. **Rhoades**. The submission of budget in the last few years, Mr. Inouye, as I and many individuals have testified before on behalf of the Administration, represents a series of extremely painful decisions about prioritization.

The **Chairman**. I'm well aware of that. We're in the process right now. But I've been told many times over, and during the short period I have been sitting here, it has been impressed upon me that this is the most serious health problem.

If this is the most serious health problem, how can your agency cut it in half? Because other programs have not been cut in half. Yes, they've been cut by 5 percent, by 7 percent, and some by 10 percent, but this is by 45 percent. If this is the most dreaded health problem in Indian country, then I would think that priority would dictate that you request all of it.

Dr. **Rhoades**. Mr. Inouye, I can only repeat that the judgment of the budget formulation individuals is that that is the amount that could be made available for this recognized number one health problem for Indian people.

The **Chairman**. Would the agency object if we appropriated more than you requested?

Dr. **Rhoades**. I'm not sure that I'm prepared to give an answer for the agency in this sense. From time to time the agency, as has been demonstrated in the last year or so, has indeed asked Congress to reconsider the amount of money that has been appropriated for various programs, and I am unfortunately not in a position to testify as to whether or not that might happen this year.

The Indian Health Service certainly would attempt to make the very best optimum use of any funds that Congress would make available for this or other programs.

The **Chairman**. What is the rate of suicide among Indians?

Dr. **Rhoades**. I don't have that data ready at hand.

The **Chairman**. I've been told it's the worst among any ethnic or national group. Is that correct?

Dr. **Rhoades**. Once again, I'm not sure that one should testify that it is the worst for any ethnic group, depending on age and so forth. However, it is clear that it is a significant and substantial problem, probably of a magnitude of a couple of times greater overall than for the United States population, and unfortunately, occurring very early in life. However, there are Indian communities where the rate of suicide is substantially less also. It is a problem, a significant problem, and appears to be related to the problem of alcohol very intimately.

The **Chairman**. I would appreciate it very much if you could submit to the committee a list of all of your major projects with the dollar figure, authorized, appropriated and spent in the last fiscal year, and the amount you are requesting this coming fiscal year.

Dr. **Rhoades**. Specifically for the alcohol program?

The **Chairman**. No, for all health programs.

Dr. **Rhoades**. Sure. Yes, sir.

The **Chairman**. I just want to examine where your priorities are.

[Information to be supplied appears in Dr. Rhoades' statement in the appendix.]

The **Chairman**. I thank you very much.

Senator **Daschle**. Thank you, Mr. Chairman.

There were a number of questions that I think would be appropriately asked. Senator Murkowski had some, and others. I will submit them for the record.

[The questions and the answers appear in the appendix.]

Senator **Daschle**. What would be the Chairman's wish? There is a vote on.

The **Chairman**. Why don't we go vote? Five-minute recess.

Senator **Daschle**. OK. We'll take a 5-minute recess and we'll be back.

[Recess.]

Senator **Daschle**. We will resume, and I think it's appropriate—unless, Mr. Chairman, you have additional questions—that we can excuse the panel?

The **Chairman**. I wasn't here to listen to the testimony, but is it correct that 1 percent of your budget is spent on alcoholism?

Dr. **Rhoades**. No, Senator Inouye; that's not quite correct. I need to remind the committee that at least 20 to 40 percent, somewhere in that vicinity, of every patient that comes into our facility for care, exclusive of childbirth, is in fact related to alcoholism in some way. The nature of the general approach that Indian Health Service makes to medical care makes it very, very difficult to dissect that out, and I'm not sure that we could do it with a great degree of accuracy. But viewed in that context, a substantially greater proportion of our budget goes to care for alcoholism.

The **Chairman**. Viewed from the other aspect, how does it turn out? We have appropriated $24 million.

Dr. **Rhoades**. Yes; If one took the $24 million and if one took the $27 million or $28 million into what I might call the "traditional alcohol programs" and compared that to the amount of clinical spending, I believe it might be a little bit less than one percent. I'm doing that in my head.

No, the decimal place would be moved over a little bit.

Senator **Daschle**. It is one percent—excuse me, Mr. Chairman. I recall a hearing I had some time ago now, and that was the figure given to me when I asked that question, that it was one percent of your budget, defined in that way, in terms of money directly attributable to alcohol treatment or prevention.

Dr. **RHOADES**. I would submit that it might be closer to four or five percent. It would depend to some extent on what we put into the denominator. For the total Indian Health Service budget, I guess it would be about one or two percent.

Senator **DASCHLE**. What is your budget?

Dr. **RHOADES**. For clinical services exclusive of preventive services, we would use a figure as of a year ago of $650 million, let's say. So if we put the aggregate $30 million over $600 million I get one-twentieth, for example.

The total budget this past year would be about $850 million, including construction activities and so forth. And in that sense—see, that's why the denominator would determine it to a large extent.

The **CHAIRMAN**. It's $890 million.

Dr. **RHOADES**. Oh. I stand corrected.

The **CHAIRMAN**. And about $24 million for alcoholism.

Dr. **RHOADES**. The alcohol and drug abuse bill contains $26 million. We have not spent all of that. And the existing alcohol programs should be about $28 million, to say nothing of the other activities related to alcohol.

Senator **DASCHLE**. Thank you, Mr. Chairman.

If there are no further questions, we thank the panel members for their participation and their answers this afternoon.

Our final witness will be John Blackhawk, who happens to be—if this is correct—from my home town. I thought I recognized the name. He's from the Aberdeen Tribal Chairmen's Health Board, Aberdeen, South Dakota.

John, we are pleased that as a result of your travails in the air you have arrived, and we welcome you and your testimony at this time. We invite you to testify as you see fit.

STATEMENT OF JOHN BLACKHAWK, ABERDEEN TRIBAL CHAIRMEN'S HEALTH BOARD, ABERDEEN, SD

Mr. **BLACKHAWK**. Thank you.

First of all, I am the Vice Chairman of the Winnebago Tribe of Nebraska, and I am here representing the Aberdeen Area Health Board.

Mr. Chairman, if I may, what I am going to do is just paraphrase some of the material and testimony that we have prepared, and also highlight some of the other material.

Senator **DASCHLE**. That would be fine.

Mr. **BLACKHAWK**. Public Law 99-570, the Omnibus Anti-Drug Act of 1986, has provided Indian people with the opportunity to make a significant impact on the ravages of alcohol abuse among the Indian adults and youth of this country. We wish to formally express our gratitude to the U.S. Congress, and especially Congressman Bereuter and Senator Daschle, for their instrumental role in developing those portions of Public Law 99-570 directly relating to Indian youth.

I would like to quote some figures, Mr. Chairman.

On a national basis, the alcoholism death rate for Indian males is approximately 4.9 per 100,000 as compared to 0.2 per 100,000 for the entire United States. For Indian females, the death rate is 1.6 per 100,000 as compared with .1 per 100,000 for the entire United States. Indian males die at a rate more than 20 times the national average, and Indian females at a rate 16 times the national average.

Ladies and gentlemen, I submit to you that this is a devastating and tragic reality.

The Aberdeen area tribes were directed to submit Tribal Action Plans by the area offices of BIA and Indian Health Service, and all tribes have done so. The plans include how each tribe proposes implementing the bill on their reservations. Many include portions which refer to a treatment center. All plans deal with prevention, education, training, family involvement, community involvement, and aftercare counseling for adults and youth.

Prior to and throughout the process, the Winnebago Tribe, as well as the Aberdeen area, have learned through experience in seeking treatment and counseling services for its youth that the amount of services available specifically for Indian youth are practically nonexistent. Therefore, over the past two years Winnebago youth have been referred to an adolescent treatment program in a nearby city. What we have learned from involvement in that program as counselors, family members and tribal members is that there is a distinct difference in the type of needs of an adolescent as opposed to an adult in regard to chemical abuse. There are elements of a treatment modality which we plan to adopt and, coupled with the overlay of the cultural and spiritual values of our people as well as the consultants and family members and counselors involved, we believe that we can develop a culturally appropriate treatment center setting for our youth.

Some of the areas that I would like to just briefly go over include the concept of rehabilitation versus habilitation. Our recommendation would be habilitation, and I could elaborate on that more if we have the time.

The other areas that I would like to mention real quickly include the reservation setting. We feel that with the current court systems and judicial systems that are in place, that being on the reservation is very conducive to coordination with our court systems as far as they relate to prevention, training treatment and aftercare. I would like to put strong emphasis on what we have found, a family-oriented type of treatment center is the most successful as far as treating youth and adults in that an individual is removed from their environment and placed in a treatment center; then after so many days have passed, they are put back in that same environment very quickly. The family orientation type of treatment or therapy would be something that we would highly recommend.

The 45-day versus the 90-day cycle—we do have the documentation to support 90 days. As late as yesterday afternoon I met with Dr. Sloan, who is our Aberdeen area director, and we are in the process of trying to get a definite committment from him in favor of 90 days.

There are two other aspects that I will mention.

Aftercare—I do not mean to take away from it, Mr. Chairman, aftercare is one of the real keys to a successful treatment program, as I'm sure you are probably aware by now.

Also, in conjunction with that or incorporated with that would be the cultural values which play and important part in our Indian traditions as far as self-esteem, and our own identification.

Moving on to budget, we have been in the process of trying to take a realistic look at the budget that we would propose and recommend. In dealing with Indian Health Service Central Office, Ms. Smith, Mr. Mason, and also in talking with Dr. Sloan at area level and his staff coordinator, our staff at the Aberdeen area—the most realistic figure that we can come up with is between $1 million and $1.5 million per treatment center. I will emphasize, that this is a figure that we arrived at through research. It is not a figure that we feel can be compromised.

When you're talking about that dollar figure, to our committee, that is the key to success. If you're going to allocate less dollars, then you're beginning to ask for miracles.

I do have some recommendations and I will go over them briefly.

As far as the selection process of primary regional treatment centers,

No. 1, the process that is developed to select the PRT's must be fair and consistent to all Indian tribes, large and small.

No. 2, tribal consultation must be incorporated in all phases of the process to select the PRT's. The tribes should be allowed adequate time to consult on the selection process.

No. 3, the process should be well publicized—an example is the Federal Register—giving tribes adequate time to submit proposals, to consult in area work plans as they relate to the area office, to respond to alternative plans to provide treatment to adolescents such as contract health service to already-existing treatment programs, etc.

No. 4, the process should be closely monitored by the Senate Select Oversight Committee to assure that the process is fair and consistent.

No. 5, the process must strongly emphasize treatment plans that are quality programs that incorporate strong and ongoing aftercare plans.

No. 6, any selection process must be weighted strongly in favor of the quality of the treatment center proposal rather than buildings and other less significant elements.

Selection panel readers, area and central office—if there is a request for proposal, and I believe this is an "if," if there is a request for proposals the panel that will review the proposals must have training and treatment skills specifically related to the specific needs of youth. What we would recommend for the composition is that at least 60 percent of the panel be composed of people who have direct expertise and experience and training in the area of adolescent substance abuse.

The selection panel should review proposals that include the family treatment concept that is culturally relevant.

If this plan is to happen, it must be done in a fashion that is fair to all tribes. A mechanism that is conducive to fairness needs to be in place so that we do not have the same problems that we had during round one of the process.

In conclusion, we wish to stress again the three words that sum up today's testimony.

Perception—Indian people know the problems of adolescent drug and alcohol abuse because we live them.

Expertise—Indian people have been treating their brothers and sisters who suffer from Chemical dependency far, far longer than the Indian Health Service

Fairness—Indian people practice, and try to practice, fairness in our family lives and in our daily lives.

We are asking this committee to assure us that our perception, our expertise, and our fairness be understood so that all proposals—if there are to be proposals—be evaluated objectively and fairly, so that the very best regional treatment center be established to meet the needs of all Indian people.

Thank you, Mr. Chairman.

[Prepared statement of Mr. Blackhawk appears in the appendix.]

Senator DASCHLE. Thank you, Mr. Blackhawk.

Mr. Chairman.

The CHAIRMAN. Sir, your testimony has been extremely thoughtful because it reminds us once again why we are here. When I assumed the Chair of this committee I stated what I hoped was the sentiment of the full committee, that for too long solutions to Indian problems have been made in Washington. And many of these solutions have not brought about the desired results. So I declared that this committee will do something a bit revolutionary. We will seek solutions to Indian problems in Indian country.

Today's hearing is a demonstration of that. We have invited leaders from throughout the country to come forward and tell us whether the solution in this bill, in this law, is adequate; if not, what would you recommend.

Your presentation makes several recommendations, and I can assure you, as you have asked us here, that your perception, your expertise, and your fairness will be not only considered, but that we will keep them in mind as we deal with this matter before us.

We will continue to seek your expertise.

Mr. BLACKHAWK. Thank you, Mr. Chairman.

Senator DASCHLE. Thank you very much, Mr. Blackhawk.

This hearing, having heard all of its witnesses, will be adjourned.

[Whereupon, at 6:22 p.m., the committee was adjourned, subject to the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Good Afternoon, I am Edward Lone Fight, Chairman of the Tribal Business Council of the Three Affiliated Tribes of North Dakota. I would like to thank Senator Inouye and the Committee for this opportunity to bring our concerns before you. I would also like to commend you for your sensitivity to Indian issues and your sincerity in carrying out your oversight responsibilities. This oversight hearing provides us with the opportunity to express concerns that cannot be addressed in other ways.

The Three Affiliated Tribes view P.L. 99-570 Subtitle C as a very important step towards the recovery of our Tribe from the devastating effects of alcoholism and substance abuse. Section 4205 (Inter-Departmental Memorandum of Agreement) and Section 4206 (Tribal Action Plans) have given us the structure and cooperation needed to effect change. We support the mandate of the law and these working mechanisms established by it. The law insures coordination and cooperation by key people and agencies which is essential to finding solutions. Prior to this law, the Bureau of Indian Affairs, Indian Health Service and the Tribe had no specific mandate or mechanism to work together.

The law is based on a Tribe using a community approach. The assumption is that the Three Affiliated Tribes must assume the responsibility for solving the problems of chemical dependency on the Reservation. This community approach is an appropriate methodology that has been proven to be effective in fighting alcoholism and substance abuse. The law has been instrumental in mobilizing the Three Affiliated Tribes for this critical battle.

The implementation of this law has its merits, but more must be done for change to occur. The areas of concern for implementation are given below. Specific data and statistics on the severity of alcoholism and substance abuse on the Fort Berthold Reservation is provided in Supplement 1.

1. In-patient treatment remains the greatest unmet need for the Three Affiliated Tribes in combatting alcohol and substance abuse. A regional youth treatment center site was not selected in the Aberdeen Area. Presently, we have no treatment center and no way to pay for treatment for the young people of our Reservation. We will be utilizing the monies provided by Section 4227 (d)1 (Rehabilitation and Follow-Up Services) to provide outpatient treatment to three rural communities. However, not all youth will benefit from outpatient treatment because they require more intensive in-patient services. Thus, the result is that many of our youth will continue to struggle with the problems of alcoholism.

2. We have substandard juvenile detention facilities. The requirement of detaining youth separate from adults

necessitates placing them in the solitary confinement cell. The detention environment for youth is more restrictive than that of adult offenders. Thus, the need for the Tribe to have a juvenile detention center is obvious. However, no information has been forwarded to the Three Affiliated Tribes regarding Section 4220 (Juvenile Detention Center) by the Bureau of Indian Affairs. This lack of communication has meant that the Tribe does not know how to access rehabilitation monies for Juvenile Detention Centers.

3. Section 4218 (Bureau of Indian Affairs Law Enforcement and Judicial Training) communication has also been limited. Currently, the Bureau is requiring training in child protection teams. However, our Tribe has been doing Child Protection Team training for two years. Therefore, the need exists to conduct a comprehensive training needs survey to determine the actual needs for respective tribes. All North Dakota Tribes presently had access to Multidisciplinary Team training from the University of North Dakota through a Child Welfare Training Grant. For North Dakota tribes, Section 4218 monies could have been used to address an unmet training need.

4. The intent of the law identified youth as the targeted recipients of services. With limited resources, it is cost effective to focus prevention efforts on the young people. However, we view successful treatment of parents as the primary prevention mode for youth. Alcoholism is a family disease and therefore it is necessary to provide

parents access to in-patient treatment for youth prevention to become a reality.

5. Approximately one-fifth of the Three Affiliated Tribes contract health care budget is used to treat tertiary consequences of alcoholism. Yet no money is allocated to prevent these consequences by providing intervention and primary treatment before the onset of complications.

6. The service delivery system on the Fort Berthold Reservation is very problematic. The Garrison Dam divided the reservation into five (5) distinct communities separated by water and distance. The cost requirements to provide services to the these communities is great in time, travel, money, and staff. If the communities were centrally located, less resources would be required to service the population. These unique characteristics require individual attention that resource allocation criteria cannot address.

7. Section 4212 (Indian Education Programs) has provided curriculum purchases and counselor training that are important areas to address. However, the limited time-frame of one year is not adequate to provide stability. For the Three Affiliated Tribes, these monies are restricted to Bureau-funded operated schools. On the Ft. Berthold Reservation, fifty percent (50%) of the school-age population attend non-Bureau funded schools. Thus, half of our young people will not have access to the curriculum purchases and counselors.

RECOMMENDATIONS

The following recommendations are a result of the concerns addressed above. These suggestions will maximize the intent of the law as it is being implemented. The Three Affiliated Tribes is sincere about fighting its own alcoholism and substance abuse battles. These proposed recommendations will help the Tribes reach its goal of a sober society.

1. Recommend that contract care dollars be made available and optional for treatment as an alternative to regional treatment centers.

2. Recommend that the Bureau of Indian Affairs provide better accountability to insure communications for development of programs by the Tribal Action Plan Committee.

3. Recommend that planning, schedules, and continuity of training programs for more than three years.

4. Recommend that funds be appropriated for Indian children attending non-Bureau funded schools on reservations. It is further recommended that those non-Bureau funded public schools located on reservations be mandated to cooperate with Tribal Action Plan Committees.

5. Recommend that adequate funding levels be appropriated for all sections of the law to insure stability and success of the programs.

6. Recommend that service delivery problems on rural and isolated reservations be given special consideration.

19 TRIBES

INTER TRIBAL COUNCIL of ARIZONA

MEMBER TRIBES
AK-CHIN COMMUNITY
CAMP VERDE YAVAPAI APACHE INDIAN COMMUNITY
COCOPAH TRIBE
COLORADO RIVER INDIAN TRIBES
FORT McDOWELL YAVAPAI TRIBE
FORT MOJAVE TRIBE
GILA RIVER INDIAN COMMUNITY
HAVASUPAI TRIBE
HOPI TRIBE
HUALAPAI TRIBE
KAIBAB PAIUTE TRIBE
PAPAGO TRIBE
PASCUA YAQUI TRIBE
QUECHAN TRIBE
SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY
SAN CARLOS APACHE TRIBE
TONTO APACHE TRIBE
WHITE MOUNTAIN APACHE TRIBE
YAVAPAI PRESCOTT INDIAN TRIBE

SENATE SELECT COMMITTEE
ON INDIAN AFFAIRS

HEARING ON
INDIAN ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND TREATMENT ACT OF 1986

THURSDAY, NOVEMBER 5, 1987

WASHINGTON, D.C.

Statement by

Donald Antone, Sr.
Governor of Gila River Indian Community
President of Inter Tribal Council of Arizona

for

Inter Tribal Council of Arizona

124 West Thomas Road • Suite 201 • Phoenix, Arizona 85013 • (602) 248-0071

Statement by Donald Antone, Sr.
Governor of Gila River Indian Community
President of the Inter Tribal Council of Arizona

Introduction

Chairman Inouye, my name is Donald Antone, Sr. I am the Governor of the Gila River Indian Community and President of the Inter Tribal Council of Arizona, an organization of 19 Indian governments in Arizona. I appreciate this opportunity to comment on the progress of the implementation of the "Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986."

The Legislation was a sincere and strong expression of concern by Congress of the severe problems of alcohol and drug abuse among Indian people. The legislation focused attention on the problems of alcohol and substance abuse, provided resources to address the problems, and mandated coordination of efforts by the Bureau of Indian Affairs, the Indian Health Service (IHS) and the Tribes themselves to expeditiously and more effectively utilize resources.

For the Tribes the legislation meant additional resources and assistance, although limited, was available to begin alleviating a major health and social problem that plagues most Indian communities.

In the Phoenix area a joint Committee was established to oversee the implementation of the Alcohol and Substance Abuse legislation. Representatives from the IHS Phoenix and Tucson Areas, the Bureau of Indian Affairs Phoenix Area and two tribal leaders each from Nevada, Utah and Arizona serve on the Committee. The Committee met regularly when the legislation was first passed and the Committee submitted a proposal for a regional youth treatment center for the Phoenix Area to Dr. Everett Rhoades.

Distribution of Funds

Congress through the law appropriated new resources for training, treatment and after care services, and construction and renovation of facilities. There was great anticipation and expectation by Tribes that these resources would be immediately available to the service units, to schools and to themselves. However in the Phoenix Area this did not occur. The Administration's Office of Management and Budget held up the release of the funds to the Indian Health Service until June of 1987. The Indian Health Service then took time to develop distribution formaulas and funds were not available to the Areas until July, 1987. The Phoenix Area, in turn, had to develop its own distribution formulas so that when the resources were finally divided up there was not enough time for Tribes that desired to contract for the funds and programs to do so. In fact, for the Phoenix Area a decision was apparently made to not provide aftercare resources to Tribes through "638" contracts. In the end the Phoenix Area Indian Health Service decided to use the additional resources to relieve the deficit in their FY '87 Hospital and Clinics budget by identifying services provided that were related to alcohol and drug abuse throughout FY '87.

Training

The law also provided for financial resources for the training of tribal and federal personnel having responsibilities for drug or alcohol abuse related situations. The training funds were available to the Phoenix Area by the end of June. The IHS Phoenix Area made the funds available to Tribes through "638" contracts. Very few tribes took advantage of these resources as the guidelines and criteria for the selection of trainers were restrictive and the time frame for submitting proposals was two weeks from the date the availability of the funds was announced.

An additional problem with the training effort by both the Indian Health Service and the Bureau of Indian Affairs was the severe lack of coordination, although the law specifically mandates that coordination of training be established through the tribal coordinating committee. Training schedules and dates conflicted, agenda topics at times were marginally useful, and usually tribal personnel were not aware of the training sessions at all.

The Tribal Coordinating Committee according to the law is to be responsible for scheduling federal, tribal and other personnel for training in the prevention and treatment of alcohol and substance abuse. The federal agencies need to provide directly to the tribes all information on training possibilities so that tribes, service units and agencies can jointly plan the necessary training.

Bureau of Indian Affairs

With regard to the Bureau of Indian Affairs for drug and alcohol prevention and treatment related efforts, the Bureau distributed its resources in a very restrictive manner. The Bureau identified only Bureau funded schools as the recipients of most of its appropriated funds. Only 10% of the Indian children attend Bureau funded schools. The resources for counseling, intervention and staff training were directed only to this small school population. Most Indian students attend public schools and at least 30% of the Indian youth in Arizona can be identified as drop outs. Given this situation, the Bureau could have planned the use of funds to the benefit of many more Indian youth. If additional funds are made available to the Bureau of Indian Affairs, the Bureau should plan with Indian tribes how best to target and reach Indian youth.

Regional Treatment Centers

The law provided for the construction or renovation of a regional treatment center for youth in each of the Indian Health Service Areas. Residential treatment facilities for Indian youth have not been available in the past. Therefore the possibility of having access to a resource raised great expectations and generated hope for Indian people. However, it was soon clear that the construction or renovation of eleven treatment centers, plus the cost of staffing for the centers, was impossible given the limited amount of funding available for the endeavor. If the Congress is truly committed to the establishment of regional treatment centers, then the funding for this effort must be increased. The need for such facilities is well documented.

An additional problem exists within the law. The law provides that federally-owned structures may be identified and used for a residential or regional treatment center for youth. In the Phoenix Area a tribally owned facility has been identified as appropriate for renovation for a residential treatment center. However, because of the language in the law that refers to a "federally - owned structure" that would be suitable for renovation, Indian Health Service has determined that tribally owned structures cannot be renovated. Clarifying language is needed that allows for tribally-owned structures to be renovated as long as the structure meets the required standards.

Conclusion

Despite the implementation issues with P.L. 99-570 the legislation remains extremely important because it has focused attention and resources on the number one health and social problem affecting Indian people and Indian communities. The majority of the Tribes in the Phoenix Area have passed resolutions to establish their Tribal Action Plans as called for in the legislation and the development of Tribal Action Plans is proceeding. The Phoenix Area will again be submitting a proposal for a regional youth treatment center.

There needs to be continued improvement in the area of coordination between the Bureau, IHS, and tribes to further the intent of the Act and to maximize resources. The federal agencies must acknowledge the authority of tribes in designing service delivery systems to avoid issues such as those involved in the development of standards for programs. Such an issue was raised in the development of standards for child protection teams. (See attachment)

As Indian governments we understand the need to reduce the overall federal budget deficit. However, alcohol and substance abuse in the Indian community does need special attention and financial support. We, the Tribes in the Phoenix Area, commend Congress for focusing attention and resources on this problem and we are especially grateful for this committee's continued support of Indian Tribes and people. We encourage and urge the Committee to support continued funding to fully implement the "Indian Alcohol and Substance Prevention and Treatment Act of 1986."

19 TRIBES

INTER TRIBAL COUNCIL
of
ARIZONA, INC.

July 22, 1987

MEMBER TRIBES
AK CHIN COMMUNITY
CAMP VERDE YAVAPAI APACHE
INDIAN COMMUNITY
COCOPAH TRIBE
COLORADO RIVER INDIAN TRIBES
FORT McDOWELL YAVAPAI TRIBE
FORT MOJAVE TRIBE
GILA RIVER INDIAN COMMUNITY
HAVASUPAI TRIBE
HOPI TRIBE
HUALAPAI TRIBE
KAIBAB PAIUTE TRIBE
PAPAGO TRIBE
PASCUA YAQUI TRIBE
QUECHAN TRIBE
SALT RIVER PIMA MARICOPA
INDIAN COMMUNITY
SAN CARLOS APACHE TRIBE
TONTO APACHE TRIBE
WHITE MOUNTAIN APACHE TRIBE
YAVAPAI PRESCOTT INDIAN TRIBE

Dr. Everett Rhoades, Director
Indian Health Services
Park Lawn Building
5600 Fisher Lane
Rockville, Maryland 20857

Dear Dr. Rhoades,

During a meeting of the Inter Tribal Council of Arizona, Inc. Social Services Working Group, ITCA staff was directed to comment on a memorandum dated May 11, 1987 regarding Child Protection Teams. The memorandum mandates the establishment of Child Protection Teams and other procedures for investigating allegations of child abuse and neglect.

As you know, most of the Bureau's social service programs, including child protective services, have been 638 contracted to tribes in the Phoenix area. Further, some tribes instituted child protective services through courts and other resources prior to 638 contracting Bureau social services. Other tribes view investigation of child abuse and neglect as a tribal police function.

The May 11 memorandum of understanding does not recognize the role of tribal governments as the governing authorities to establish standards for child protective services. Any Bureau or IHS standard should complement and support tribal customs and laws. However the memorandum establishes that tribal contracts "must comply with these standards as minimum standards."

While the intent of the memorandum is to improve services through coordination, the mandatory child protection team functions and time frames are inconsistent with child protective service operational procedures in some tribal communities. The standards impose a medical model of practice which is not neccessarily helpful in all referrals of child abuse and neglect.

We agree that coordination in child protective services may improve delivery of services in some communities. However we recommend that the memorandum of May 11, 1987, be rescinded and that the BIA and IHS meet with tribes to learn what tribal specific procedures are in place and how IHS and Bureau policy could be coordinated to improve service delivery.

124 West Thomas Road • Suite 201 • Phoenix, Arizona 85013 • (602) 248-0071

A priority would be to meet with those tribes who have procedures in place to agree upon appropriate federal roles to avoid conflicting policies. A second priority would be to meet with those tribes which do not have fully developed childrens codes and assist them to develop codes upon request.

It is recommended that local tribal-federal agreements rather than national mandates be adopted to insure intergovernmental coordination in addressing child abuse and neglect issues.

Please contact me if you have any questions.

Yours Truly,

John R. Lewis
Executive Director

cc: Robert Marsland, Acting Director, ✓
Phoenix Area Indian Health Service
Social Services Working Group
Juvenile Justice Working Group

WRITTEN TESTIMONY
COMMENTS ON P.L. 99-570

Submitted by
The Cheyenne Arapaho Tribes of Oklahoma

The Cheyenne and Arapaho Tribes appreciate the opportunity to submit comments and recommendations relative to the effects of P.L. 99-570 and the results of implementation efforts made during its first year. Chiefly, these comments reflect the views of administrative personnel and offices because the lengthy delays by various federal agencies in implementing several important features of the legislation made it virtually impossible for tribes to initiate actual programs before the fiscal year ended.

The general flurry of excitement and anticipation that federal officers and tribal leaders exhibited it the early months following passage of the law waned rapidly during late Spring and early Summer as other problems and policy initiatives competed for the attention and time of top- and mid-level federal officials, e.g., the "EARN" initiative of the BIA and the study of alternative health funding plans by IHS. Once the Secretaries of HHS and DOI completed the Memorandum of Agreement, as required by the law, it appeared that the effort lost considerable momentum. Part of this effect was undoubtedly the direct result of the reduced funding actually appropriated for the legislation's implementation.

This waning of enthusiam was accompanied by - and perhaps contributed considerably to - a lack of direction and vagueness of [illegible]pose on the part of the Bureau of Indian Affairs. It has often been difficult to elicit positive, specific responses from officials at several levels of authority to questions or problems in the area of concern.

Additionally, the lack of full funding for the legislation severely taxed the capabilities of Indian tribes to implement effective, efficient actions and programs and, in some instances, to develop a satisfactory Tribal Action Plan. This aspect, coupled with the fact that the BIA's construction funds allotted were not distributed to meet the purposes intended by law, has critically limited the results of the initiative thus far.

As with so may federal programs of the past few years, the approach that makes it necessary for Indian tribes to compete against each other for funds to address serious problems has a very deleterious and inervating consequence. Additionally, it is everywhere evident that large tribes with resources, with more educated personnel and with political power receive the contracts and the grants, leaving the small tribes further behind and struggling to survive.

The non-recurring funds for prevention that were made available through Indian Health Service were barely significant for the various Tribes, in comparison to the magnitude of the problem experienced by many Tribes throughout the nation. It would appear that IHS, at the national level, is not sufficiently aware of the magnitude of the problem in some areas of Indian country and is not knowledgeable about the limitations of tribal resources that are thought to be available to tribes in the non-reservation states, such as Oklahoma and California.

The approach, as set in action by the federal agencies in several service areas, appears to be piecemeal and disjointed. The coordination between BIA and IHS has been ragged and slow in becoming useful, with considerable work in this area yet to be done.

There has been a noticeable lack of information available that should have emanated from the Memorandum of Agreement between the two Secretaries. If such information was generated, to whom was it distributed and when?

To the credit of IHS, the Cheyenne and Arapaho Tribes received a significant increase in operational funding for alcoholism prevention, treatment, and personnel training. Developmental activities are now underway; actual results from the use of these funds are still several months away, with long term effects some years in the future.

The establishment of the additional regional treatment centers, mandated by the law, needs to be fully implemented. The regional center to be developed in eastern Oklahoma, when completed and operative, will only scratch the surface of need in this state with the nation's second largest Indian population. Similarly, the need for prevention and intervention programs for youth, and especially for very young children who are members of families that abuse alcohol, is very critical. If the deadly spiral of drug and alcohol abuse is to be broken, it must come through education and changing behaviors before patterns are developed and attitudes are firmly set. A survey of 500 Cheyenne and Arapaho households, just completed, reveals that 80 per cent of the adults have used alcohol and that 50 per cent were under 18 years of age when it was first tried; only 36 per cent of the adults classified themselves as non-drinkers. Many more local facilities and trained personnel are severely needed if any real progress is to be made in ameliorating the problem.

In view of the situation that, in our perception and experience, has developed since the inception of the legislation, and in view of the pervasive and intensive need of tribal people and governments as we battle to control the problem it was meant to address, we respectfully recommend the following for the Committee's consideration and deliberation:

1. Renewed emphasis on results at all levels within the appropriate federal agencies;
2. Increased emphasis on the development of Memoranda of Agreements at the Area Office level between the federal agencies and on implementation of terms and content of these MOA's;
3. Greater coordination among federal and state agencies, expecially with regard to education, prevention, and personnel training;
4. Development of all mandated regional treatment centers and creation of new, local, easily accessible prevention and treatment centers;
5. Increased emphasis on public awareness and research; and
6. Non-competitive funding of programs demonstrating sound planning, approach, and committment to address the problem at the basic level, with high prioirty given to total family intervention.

the Chickasaw Nation HEADQUARTERS
Arlington at Mississippi / Box 1548 / Ada, OK 74820 / (405) 436-2603

Bill Anoatubby
Governor

Kennedy Brown
Lieutenant Governor

C. & A. TRIBES
RECEIVED
NOV 2, 1987
Time
Per
Concho, Okla.

October 29, 1987

Mr. Wisdom Nibbs, Chairman
Cheyenne-Arapaho Business Committee
P. O. Box 38
Concho, Oklahoma 73022

Dear Chairman Nibbs:

We appreciate your letter informing us of your intention to testify at the Congressional oversight hearings concerning the implementation of the Indian Alcohol and Substance Abuse Prevention and Treatment Act, Public Law 99-570.

A major concern we have is that these funds were only for a one time distribution. Prevention activities should be an ongoing process in all alcohol/drug programs.

Another concern we have is the slowness with which agencies, Indian Health Service and the Bureau of Indian Affairs, have responded in getting the funds to the tribes. Indian Health Service finally made an allocation of funds late in the year and then only for a small amount. The Bureau of Indian Affairs has placed a freeze on construction funds and can't seem to give any information to the tribes.

Unless some policy can be mandated to ensure that tribal needs are addressed in a timely manner it will remain, once again, our people who suffer the consequences.

Your willingness and assistance in presenting our views before Congress is greatly appreciated.

Sincerely,

Bill Anoatubby, Governor
Chickasaw Nation

fc

TESTIMONY TO THE SENATE INTERIOR SUBCOMMITTEE HEARINGS REGARDING THE IMPLEMENTATION OF THE INDIAN ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND REHABILITATION ACT OF 1980

(PL 99-570)

by

The Navajo Division of Health
Navajo Nation
P.O. Box 1390
Window Rock, Arizona 86515

November 5, 1987

NDOH, 5 Nov 87

Thank you for the opportunity to speak before you this morning. My name is Katherine Arviso, and I am Executive Director for the Navajo Division of Health. My testimony before you this ~~morning~~ afternoon concerns the opportunities and problems which we, the Navajo Tribe, have experienced in implementing PL 99-570.

The Act was conceived with the intent of insuring that the Bureau of Indian Affairs, the Indian Health Service and Indian tribes would make lasting and long-overdue arrangements to coordinate existing services and resources, and refocus more efforts more toward prevention. The Act has allowed us to make a number of gains, but barriers have arisen which need to be addressed, so that the organizational intent of the Act can be fully achieved.

Background to Navajo Tribal Response

The Navajo Tribe was fully informed of the Act by February 1987, and responded to the prototype Memoranda of Agreement between the Departments of the Interior and Health and Human Services. From there the Chairman's Office convened a Strategic Work Group (SWG) which consisted of different Tribal staff delegated by their respective directors, IHS representatives, BIA representatives, and officials from the Navajo Health Systems Agency. This group was to (1) compile information on the extent of the substance abuse problem, (2) determine available resources, (3) draft a Tribal Action Plan, and (4) inform Tribal executive offices and community leaders of Tribal efforts.

As of this date, a Tribal Action Plan has finally been submitted to the Navajo Tribal Council for ratification. As required by the Act, the Plan contains a description of the extent of the problem, available resources, goals for addressing the problems, and a brief overview of issues relating to implementation..

Problems in Implementing the Act

It does not, however, outline the means of implementing the Act itself, and the reasons include: (1) organizational problems within the Tribe when the present administration took office, (2) problems in relationship with the federal government in drafting this plan, (3) wider-ranging problems in data base management and planning, and (4) non-coordination with state activities.

Internal Organizational Problems

The Tribal bureaucracy was not really prepared to take the lead in implementing this Act. In an effort to curtail the bureaucracy entanglement, the Chairman's Office delegated the Division of Health as the lead agency in coordinating Tribal, Bureau and IHS efforts. As this effort moved forward, it soon became clear that (1) data among the different divisions documenting the problem of alcohol/drug abuse were disaggregated and not translatable from organization to organization. (2) Many programs whose activities were affected by substance abuse, such as in economic development, did not at first see themselves as directly affected by the Act, and therefore did not participate actively. (3) Because the Navajo Reservation constitutes a Service Area, service units began initiating their own plans. Many of them felt that it was better to coordinate Federal, Tribal and local efforts at the Service Unit level, and then deal directly with the appropriate Federal Office, thereby bypassing the Tribal coordination efforts. As a result, many of the service units and surrounding communities drew together uncoordinated plans, each of which emphasized a local boosterism advocating the location of the Residential Treatment Center within their respective communities. (4) Tribal Departments, such as Education, Social Welfare, Law Enforcement and Public Safety are funded primarily through PL 93-638 contracts and grants with the Bureau of Indian Affairs, while the Health Division deals similarly with IHS. There was thus a tendency for all the different departments to be pulled more strongly toward interaction with their respective Federal contracting agency, rather than within the Tribe, and this was not discouraged by the respective Federal entities.

As a result, the overall effort tended to be fragmented, delayed, and diffuse. Programs thought more about how to spend money quickly, as soon as they heard about it, rather than attempting to formulate long-term plans, and this was encouraged by the Federal Agencies, since their own planning resulted in last-minute efforts.

Problems in Federal Relationships

The Indian Health Service Facilities Maintenance group were very helpful in analyzing the feasibility of different facilities proposed by the different booster groups for the location of the Residential Treatment Center. This help amounted to little, however, because of difficulties surrounding the TAP. Problems involved apparent lack of coordination from within the BIA and IHS, lack of technical assistance, and unilateral acts to which the Tribe's input was ignored.

Coordination. Much of the help provided by IHS was not coordinated through the Tribal offices. IHS helped individual tribal members, but not openly. As a result, factions both within the Tribe and IHS tended to disagree with the contents of the Plan, and periodically disassociated themselves from it.

A strong form of paternalism could be seen in the ways in which Federal officials provided technical assistance. IHS and Bureau tended to foster a form of neurotic dependency on Tribal members as individuals. First, Federal staff took a largely passive role at planning meetings, posing questions on procedure for which they never produced answers. They would then later, outside formal decision-making meetings, approach individuals in charge of writing certain parts of the plan, assure the individuals that the Tribal staff were drafting the plan all wrong, and then offer to do the writing for them.

Second, when Tribal staff who took strong stands on self determination took initiative in organizing Tribal efforts, the federal staff would boycott and in other ways undercut Tribal leadership.

Technical Assistance. When Tribal Action Plan drafts were completed, IHS tended either officially or unofficially to maintain that a particular draft was inadequate. They failed, however, to explain their reasons. This pattern of input had two unfortunate effects. On the local level, it meant that different factions and subgroups tended, at any one time, to work on the TAP. On the national level, it meant that a proposal for regional treatment center was never completed adequately for favorable consideration.

Unilateral Decisions. It was not until early September that the Tribe, BIA and IHS managed to agree on who was to do the work, and how it was to be done. The result was a "committee document" which contributed nothing to actual implementation of the Act. Both the Bureau and IHS, meanwhile, proposed their own plans for spending of the money that they were receiving, and of which the Tribe was informed only at the last minute. The Tribe, upon review of these plans, submitted their own counter proposals in line with the final Tribal Action Plan. These were ignored, and over 1/3 of the funds for youth substance abuse treatment and prevention were routed by IHS for their own purposes. IHS explained openly that they plan to fund these positions through the Resource Allocation Methodology after the end of the Act. This means that funding after the end of the Omnibus Drug Act will be at the expense of programs already funded by IHS through PL 93-638.

Data Base Management

It appears that some of the census data, incidence data from Law Enforcement and Public Safety, and other sources independent of IHS will be very valuable as an independent evaluation on IHS data. The latter have been plagued for years with 3 major problems. (1) For IHS in general, data are based on Ambulatory Patient Care (APC) reports from clinics. These form the basis of the Resource Allocation Methodology. For Alcohol treatment programs, the reporting unit is the Alcohol Treatment Guidance System (ATGS). In both cases, the data are notoriously imprecise because of difficulties in enforcing proper reporting, and in compiling these data.

(2) Because these data are based on workload, it will be difficult to determine accurately the outcomes of prevention programs. For example we may ask whether or not a smaller incidence of referrals for a problem is due to the program's success, or actually because for some other reason, people are simply not seeking care.

(3) The census-based data are not well estimated. A comparison between the first reports from the 1980 census and the 1987 estimates showed the same ratio between individuals aged 15 - 44 to the rest of the population. Only the numbers had been calculated upward by a linear formula to account for expected population increase. Rather obviously, this state of affairs is unlikely to happen in the real world. The result is unfortunate. Therefore, the data are usable only for documenting the need for alcohol treatment and prevention funds to the Navajo Area at large. They do not help setting priorities. They are useless, for example, in estimating communities or regions of greatest risk, of testing hypotheses of why they may be at risk, or of determining what or how certain areas may be best treated. Such knowledge is needed if we are to use scarce resources

There are three solutions. First, there is software available to estimate the population more accurately, according to known demographically-based estimates. Second, the incidence data from other agencies can be used as a validity check on the IHS data. Third, and most desirable, is a combination of the two. So far, however, Tribal attempts to coordinate or improve such data analysis have received no support from IHS or BIA.

IHS data are the dominant data used for documentation of the extent of the problem. The Omnibus Drug Act, to us, mandates such reforms in our data base. If some sort of reform is not undertaken, this mandated part of the Act will not be realized.

Relationships with the States

The states and non-departmental federal efforts illustrate another problem in lack of coordination. It is clear that the states have received large block grants from the Omnibus Drug Act, and some of that is directed for Indians not benefitting from services on-Reservation. It is also clear that some of them have made their own plans. The State of New Mexico, for example, has established a state-wide project for coordinating the use of funds, some of which are spent on prevention in Reservation bordertowns such as Farmington.

While it is possible that the states are concerned about possible Indian efforts to utilize some of those funds, it is equally possible that they are falling back on the well-established pattern of ignoring Indian Tribes because they are purportedly federally-funded. Indians, as tax-payers of these states, are citizens who are subject to state laws. Even if the Indian Tribes receive no monies from the states, Indians have the right to be involved in decision-making which directly affects their lives.

Recommendations

The following recommendations are intended to cover the Navajo Tribe as well as the IHS and BIA. From the Federal side we recommend the following:

A. IHS and BIA's internal coordination must be coordinated with the Making available abbreviated reports is not sufficient. Plans based on this coordination must follow the Tribal Action Plan.

B. Submission of proposals and Tribal Action Plans must follow at least some guidelines and regulations similar to those usually set forth in Codes of Federal Regulations. For a Federal funding agency simply to favor one plan over another without a set of minimum standards for proposal preparation is negligence. Such requirements can be maintained without losing flexibility.

C. BIA and IHS should either actively pursue attempts to broaden the scope of data base and statistical management, or should make special provision to support Tribal initiatives to do so.

From the Tribe itself, certain initiatives are necessary, and we have already begun pursuing them.

A. In response to the need for better accountability from the Bureau and IHS, the Tribe must assemble the Coordinating Committee which will oversee all activities, and actually implement the Tribal Action Plan already drafted.

B. The Tribes must take the lead in evaluations of contract health services related to alcohol/substance abuse treatment and prevention, and draft minimal mandatory and policy standards for these endeavors.

C. The Tribe must take the lead in contracting much of its funding to independent Tribal entities who can deliver services. This will (1) make available a wide range of prevention options hitherto unknown, (2) provide the opportunity for systematic evaluation, and (3) provide an incentive for other Tribal organizations to actively develop programs.

D. The Tribe must also take the lead in expanding its treatment and prevention capabilities into bordertowns and other off-Reservation areas where Navajos congregate to do most of their drinking.

E. Prevention and community education should be made available, through the Tribe, for the widest range of agencies and school systems serving the Navajo Reservation. Three major school systems serve the Navajo Nation: BIA, Contract, and State Public. This concern thus assumes paramount importance.

It should be clear that the problems associated with the implementation of the Omnibus Act are or an organizational nature. They are for the most part easily solvable, but somehow, Federal requirements should be put in place to ensure that those Federal agencies involved do not continue to be part of this problem. Those not immediately solvable, such as the data base management issue, can be planned for. The point to stress is that failure to work closely together adversely affected the whole Navajo Area, both Federal and Tribal.

There is a lack of preparedness which is to a degree perpetuated by the ingrained paternalism which remains with the Federal, and to a lesser degree, state, governments. It is difficult to recommend how to deal with this paternalism, but it is hoped that the Omnibus Drug Act is a window of opportunity for dealing with some of these long term issues. Thus, the above comments are thus an indicator of our continue interest in endeavors connected with the Act.

seattle indian health board

Testimony of the
Seattle Indian Health Board
before the
United States
Senate Select Committee on Indian Affairs

Oversight Hearings
on the

Indian Alcohol and Substance Abuse Prevention
and Treatment Act, P.L. 99-570

held

November 5, 1987
in
Washington, D.C.

Presented by: JoAnn Kauffman, M.P.H.
Executive Director

p.o. box 3364
seattle, washington 98114

area code 206
324-9360

Mr. Chairman, I am here today to testify before your committee on the issue of alcoholism among Indian and Alaskan Native people and to offer recommendation on the implementation of P.L. 99-570 and other related legislation.

The Seattle Indian Health Board was incorporated in 1970 to provide health services to the thousands of Indians and Alaskan Natives in the greater Seattle area. These Indian people suffer significant health problems, but are for the most part ineligible for IHS services primarily because of their geographical relocation away from their tribal community. In 1972, the Seattle Indian Health Board was among the first Indian alcoholism treatment efforts funded in the United States through a special initiative of the National Institute for Alcohol Abuse and Alcoholism (NIAAA). This early effort was sparked by a man named Ernie Turner, who for ten years directed our alcoholism treatment services and who provided advocacy for the treatment of Indian alcoholism nationally.

Our focus on alcoholism treatment provided the means for many Indian people to find a path towards recovery and to become leaders themselves in the Indian alcoholism movement. Inpatient treatment was later added to our service system in 1975.

Then, in 1976 with the passage of the Indian Health Care Improvement Act (P.L. 94-437) all Indian alcoholism treatment programs funded by NIAAA were transferred to the Indian Health Service (IHS), including the Seattle Indian alcoholism program. This transfer to IHS offered our alcoholism treatment services some stability in funding and enhanced the integration of alcoholism treatment into the overall health services framework for Indian people in the city and on reservations.

Our relationship with tribal communities in the Pacific Northwest and Alaska began to develop and our 46 bed inpatient treatment program known as the "Thunderbird House" became a regional resource for alcoholism treatment. To provide these treatment services we utilize IHS, State of Washington and patient generated resources. In calendar year 1986, our 46 bed facility had 70% of its beds filled all the time, and during that year we treated Indian patients coming from broad spectrum of tribal backgrounds. They included:

Makah
Tlingit
Athabaskan
Gros Ventre
Spokane
Arikara
Yakima
Modoc
Haida
Shinnecock
Blood
Cochiti
Salish
Otoe
Yaqui
Crow
Cherokee
Colville
Blackfeet
Cree
Navajo
Ojibway
Aleut
Tulalip
Shuswap
Muckleshoot
Chehalis
Cheyenne
Ysleta
Swinomish
Hualapai
Klamath
Eskimo
Flathead
Chippewa
Cowlitz
Sac & Fox
Coeur d'Alene
Tsimshian
Assiniboine
Lumbee
Sauk-Suiattle
Arapaho
Cherokee
Clallam
Suquamish
Winnebago
Yuchi
Apache
Sioux
Cowichan
Choctaw
Tulelo
Nisqually
Nez Perce
Quinault
Siletz
Kootenai
Stillaguamish
Nootka
Ottawa
Umatilla
Inupiat
Seminole

The language contained in P.L. 99-570 does not recognize the alcoholism treatment structure already in place, such as the fifteen year old treatment program serving both reservation and urban Indians in Seattle. Rather P.L. 99-570 has set out a series of mandates based on the IHS service unit structure referencing the role of tribal governments, but making no mention of Indian alcohol treatment centers which are not tribally or IHS operated. The effect of this omission has been to create an unnecessary wedge between our Indian treatment center and the intended activities of P.L. 99-570.

Likewise, Indian populations residing in urban areas which lack Indian alcoholism treatment resources are at a further disadvantage. The omission in P.L. 99-570 to address Indian populations in urban settings seriously compromises any national effort to address and effectively arrest alcoholism in the Indian population.

Our inpatient treatment capacity substantially increased last year when we relocated our 46 bed operation to a larger, more sanitary 95 bed complex which also allowed segregation of services for male, female and adolescent treatment. While the State of Washington was willing to grant added public assistance sponsored treatment beds, the Indian Health Service has offered no additional support except the explanation that we do not quality for funding under P.L. 99-570. Portland Area IHS is just now contemplating a means to pay for adolescent treatment on a per person basis. The rate of reimbursement for Indian Treatment Programs however is far below the cost of providing the services based in IHS Resource Allocation Formula. For other non-Indian treatment centers IHS plans to pay a higher, market rate. This seems to be a significant contradiction to the intent of P.L. 99-570. Indian treatment programs need to be given the resources and recognition they deserve when providing culturally sensitive and therapeutically sound alcoholism treatment to our own people.

The fifteen years of SIHB experience treating Indian alcoholism has taught our agency the benefits of an integrated system which also provides medical, dental, mental health, cultural and community support for the recovering alcoholic and his or her family. SIHB recommends the IHS adopt a holistic approach to alcoholism and utilizes its full range of resources including mental health, maternal child health, hospital, clinics, CHR's and other opportunities available to enhance community change.

Right now, the Seattle Indian Health Board is in the midpoint of a two-year national demonstration project funded by the DHHS Secretary's Office of Minority Health, to "prevent Indian mortality due to alcohol." Our effort is an intertribal team prevention approach involving the 10 tribes in Puget Sound and Seattle's urban community. Based on our research in Seattle done by SIHB and by Dr. Dale Walker we know that

- 54% of the Indian adult population is actively involved in the progression of alcoholism;
- 80% of the Indian adult population grew up in an environment where alcoholism affected someone in their family;
- children from alcoholic home are at a higher risk for becoming alcoholic or alcohol abusers;
- children from alcoholic homes are at a higher risk for being victimized by physical, sexual or emotional abuse.

Indian alcoholism is an intergenerational disease. It's prevention must address the intergenerational factors leading to alcohol addiction and the tolerance of alcoholism as a way of life that is passed on by those 80% of us growing up in its midst.

Our prevention effort focuses on the needs of "Children of Alcoholics." special trainings have been developed for Indian communities to understand alcoholism's intergenerational effects. Several Northwest Tribes have asked for the training SIHB has developed around COA to be given to their communities through P.L. 99-570 activities and it is not clear to SIHB or to the many tribes with whom we work why there is this need to separate out urban Indian alcohol resources such as SIHB from P.L. 99-570 activities, particularly in light of the request from Tribes for our specialized COA training.

Future amendments to P.L. 99-570 must seek to create a way for Indian communities and IHS to view alcoholism as a disease which has many more victims than the individual alcoholic. The families of alcoholics need at least as much, if not more, support as the alcoholic. The paid of living with alcoholism, while not readily quantifiable, is manifested in the myriad of health and social problems faced by Indian communities including child abuse, sexual abuse, suicide, school failure, domestic violence, depression, low self-esteem and family disintegration. These dysfunctions are handed from one generation to the next unless there is adequate support for the children who struggle for survival.

In October 1987, the State of Washington sponsored Indian leaders from all the tribes in the State to travel to Alkali Lake, B.C., for a three day training on community change. What we learned was that community leadership must take a personal stand against alcoholism and promote individual and community-wide healing. P.L. 99-570 offers a start. With continued attention and amendments, INdian communities can realize a time when the cycle of addiction has been broken.

In summary, the following recommendations are made:

1. Provide corrective language in either the Indian Health Care Improvement Act on P.L. 99-570 which allows urban Indian populations to be eligible to receive IHS support to develop alcoholism treatment services.

2. Provide instruction to IHS to reimburse Indian inpatient alcoholism treatment centers at a rate comparable to the market or at least comparable to the cost of the service delivered.

3. Provide language in either the Indian Health Care Improvement Act or P.L. 99-570 which provides intervention and treatment for children and families of alcoholics.

4. Recommend appropriations in FY 89 for Urban Indian Health programs to receive funding to provide alcoholism intervention and treatment in the Title V clinics.

JAK:hsb
11/4/87
\MSWORD\TESTIFY.DOC

Alcoholism seen as enemy No. 1 of Indians

'It's killing Indian people deader than doornails'

By Ashley Dunn
P-I Reporter

Washington's Indians:
TRIBES IN TRANSITION

One of John Boyd's earliest memories is of his grandfather lying motionless in a field on his native Lower Elwha reservation near Port Angeles.

"He was drunk, passed out," says Boyd. "I kept my distance and watched out for him but I didn't really understand."

Today, Boyd, 28, understands only too well. Like his grandfather and his father before him, he is the latest generation to face a grim family legacy, alcoholism.

He has beaten his wife, disappeared from home for days on end and failed to realize a dream of finding more in life than did his parents, all because of drinking, Boyd says.

"It's really a vicious cycle," he says. "Somebody in our family has to recognize it and not just say that's the way it is."

Alcoholism is the single most important issue facing Indians today, says JoAnn Kauffman, executive director of the Seattle Indian Health Board, a non-profit organization that provides health care to Indians and Alaskan Natives in the King County area.

"Whether we have the ability to turn that around is the future of the Indian people," she says.

The problem cuts across all tribal boundaries and is experienced in every section of the Indian community, both on the reservation and in the cities, Kauffman says.

"It's killing Indian people deader than doornails," Kauffman adds.

She cites federal research that Indians die from alcoholism at a rate 550 percent greater than the general population of the country.

The reasons for the high rate of Indian alcoholism are unclear, Kauffman says, but there are several possibilities.

A way of life

She points to high unemployment among Indians, low self esteem, poverty and even biological or genetic factors.

Perhaps the most common problem is that drinking has become accepted as a way of life for many Indians, she says.

Boyd, now in a two-month alcohol rehabilitation program at Seattle's Thunderbird Fellowship House, took his first drink at age 5, when he was offered a sip of beer by a relative.

He began drinking heavily after graduating from high school. It was a way to be with friends and have a good time on his reservation, located about eight miles outside of Port Angeles.

JENNIFER WERNER P-I PHOTO

John Boyd's earliest memory is of his grandfather lying drunk on the Clallam Indian Tribe's reservation near Port Angeles. His father was an alcoholic, and he's being treated for alcoholism at the Thunderbird Fellowship House in Seattle.

"Instead of going to school, it was easier to go to a bar and shoot pool," he says.

He has endured drunken-driving arrests, numerous fights and family conflicts.

Just recently he was caught driving while intoxicated and went to Thunderbird as part of a court-ordered treatment program.

Thunderbird and the Puyallup Tribal Treatment Center are the two residential programs in the state for Indian alcohol rehabilitation, Kauffman said. Both programs are federally financed.

Phyllis Johnson, Puyallup treatment center counselor, says the residential programs, which require patients to stay in the facility for up to two months, give patients a safe and secure stay away from the pressures of daily life.

"It's really hard to see something is wrong when you're in the middle of it," she says. "Here, we try to give them a protected environment so they can deal with their problem without outside pressures."

Both Thunderbird, which has about 45 patients, and the Puyallup treatment center, which has about 20, give patients a heavy dose of education about alcoholism. There are also group discussions that explore each patient's reasons for drinking.

The residential programs are expensive to maintain. Federal funds for Thunderbird, which costs $348,000 a year to operate, are channeled through the Indian Health Board and the board has cut other programs to keep the treatment center going in the face of federal budget cuts, Kauffman says.

"Money we used to get for alcoholism has decreased substantially," Kauffman says. "We've been frantically digging around to patch our budget up."

In addition to the residential programs, many tribes run outpatient programs in which patients go to a clinic once or twice a week for counseling.

Tom Ziel, substance abuse program counselor for the Quinault Indian Nation, says serious alcoholism cases are referred off the reservation to residential programs.

"It costs megabucks to have a residential program and we just don't have funding to set one up here," he says.

Regardless of where one goes for help, Kauffman says most treatment programs only address the problem of alcoholism in its more advanced stages. There is little effort to educate young people before they start drinking, she says.

"The real scandal occurs in Indian country itself," she says. "People don't like to talk about it.

"The stereotype of the drunken Indian on skid road is not accurate. It's the drunken Indian in a suit at Boeing, the Indian fisherman, the Indian mother of five. By not discussing the problem we're allowing the stereotype to continue."

TESTIMONY SENATE SELECT 11-5-87 INLAND TRIBAL CONSORTIUM

Mr. Chairman, my name is Nadene Naff, I am on the Business Council of the Colville Confederated Tribes. Today I am representing a consortium of seven Tribes as follows: Nez Perce, Coeur d' Alene, Kalispel, Kootenai, Spokane, Umatilla and Colville with a total combined membership of 32,000 Native American Indians.

Thank you for allowing us to testify on PL 99-570 today.

The Tribes represented here today are all located in the Eastern regions of Washington, Oregon and the western area of Idaho. We are all geographically, culturally and traditionally plateau tribes and co-mingle with each other. (Map Exhibit A)

Tribes of the Inland Tribal Consortium (ITC) have united together on this important bill, pooled our problems, concerns and resources in a co-ordinated effort to help our people and the U.S.government in our common goal.

On October 17, 1986, Congress enacted PL 99-570, the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 to address the abhorrent conditions in Indian country related to alcohol and other mind-altering drugs. This legislation is the first order that mandates Bureau of Indian Affiars and Indian Health Service to work together and is monumental. The actions authorized by the Bill would have a major impact on the devastating conditions of Indian families, but the monetary appropriations to accomplish this are inadequate. Although BIA and IHS are mandated to work together to implement PL 99-570, there has been virtually no participation by BIA at the local level and very little from the Portland Area level. The director of Bureau of Indian Affairs alcohol office has had no communication with Tribes. The Bureau of Indian Affairs has failed to conduct any training on how proposals should be developed or any policy related to this Bill. Further, to our knowledge there has never been a formal grant application package.

First, Indian Health Service and the Bureau of Indian Affairs are mandated to conduct a needs assessment. To accomplish this, Indian Health Service and Bureau of Indian Affairs delegated Tribes to carry out the mandate. It immediately became evident that data did not exist to accurately validate the intensity of problems with substance abuse on Indian Reservation. None of the pertinent agencies have a device to record, analyze, or network information on clients or patients. In 1971 and 1972 the Colville Service Unit compiled data within a 14 month time period and we know of thirteen deaths from alcohol caused illnesses. If we had this data as was available in 1971 and 72, we could give you the cost breakdowns on resulting accidents, injury and directly related diseases. We firmly believe that this would be a devastating figure. Therefore, dollars spent now in prevention and recovery is a small amount in comparison.

Portland Area Tribes were directed by the Indian Health Service Area Alcoholism coordinator to submit Tribal Action Plans, TAPS by July 15, 1987. We were informed that the most innovative comprehensive plans would be considered eligible for more money. Additionally, information was handed out at the July Northwest Portland Area Indian Health Board meeting of the funding amounts per tribe. Tribes were not instructed on how to access those funds, and all tribes did not receive this information. But in September and October when staff queried the area office as to TAP monies, we were told there were none. The Northwest Portland Area Indian Health Board members represent the 12 service units, not the 38 tribes of the Portland Area. The IHS officials specified that TAPs would determine funding, when actually Resource Allocation Methodolog (RAM) was used to determine funding levels. All of us, as tribal leaders wonder how RAM can be used when the RAM process has not yet been approved. The RAM formula to determine allocation of prevention monies is based on numbers provided prevention services in the previous fiscal year and on population. This formula disregards the geographic conditions such as the cost of travel in remote areas and distances between towns and over mountain passes. Further, the Tribes that did not have prevention programs in the previous year are again penalized as they have no base.

Criteria for funding was not provided, in fact, in the beginning we were given information that there were no limitations to our plans. Tribes who sent in plans for IHS special project funds were required to re-submit plans because they did not meet IHS criteria. The release of funds to tribes by BIA and IHS was nonsensical. TAP development funds from BIA were received two months after the TAP deadline.

Portland Area tribes have not been allowed to participate in the decision-making process in implementation of Pl 99-570. A record of our objections to the local area office are enclosed as Exhibit B. Decisions on spending plans, action plans and training are made by IHS solely. Colville Resolution 1987-171 responds to information extracted from IHS-PAO Executive Committee minutes and OPPOSES plans to channel $300,000 into contract health services, rather than a regional treatment center and is enclosed as Exhibit C.

The Northwest Portland Area Indian Health Board conducted a poll for site selection of a Primary Residential Treatment Center (PRT). Who voted? The Tribes? The Service Units? However, we were told the majority voted to expand the existing facilities on the West Coast. The Inland Tribal Consortium tribes would like a clarification of this process as our people East of the Cascade

Mountains comprise more than half of the total Portland Area IHS user population and we have a right to know. We do know the Kalispel Tribe, for instance is not a member of the NPAIHB and they were not consulted.

Additionally, "Use of existing federal facilities" is a required criteria for selection of youth regional treatment centers under PL 99-570. Areas that have IHS Hospitals would find no problem with this. However, the Portland Area does not have an IHS hospital, but we most certainly have a need for youth inpatient treatment. In the Spokane/Coeur 'd Alene metropolitan area there are no available federal facilities. We have requested information on any vacant facilities through GSA, and have been informed there are no facilities. It is our recommendation that the criteria for Cong. Rec. H. 11263 Oct. 17, 1986. "use of existing federal facilities" be modified to accommodate tribes and areas in which there are no existing facilities.

Further, the staffing pattern set by IHS does not include elders, spiritual leaders nor cultural specialists. Indian education and substance abuse professionals have found that culture and spiritualism must be integrated throughout the continum of care from intervention/prevention to aftercare.

In the Portland Area and Nationally, an elite few are invited to contract as consultants and trainers. Indian groups have been providing training on PL 99-570 and the University of Minnesota has been contracted to implement an adolescent health survey. Not all Tribes and Indian organizations have received the Request for Proposal (RFP) information to apply for these projects.

National forums for information and updates from BIA and IHS headquarters is needed, as well as area wide training to provide area level policy, funding and tribal participation in the implementation of PL 99-570. These meetings must include tribal leaders as well as staff who are responsible for the implementation of grass roots programs. For instance, training in the Portland Area has all occurred on the West side which continually burdens tribes east of the Cascades. Therefore, Exhibit D Colville Resolution 1987-172 requests participation in the selection of training sites and topics. Also, language of the Bill excludes youth training and youth activities. Surely the spirit of the law did not intend to omit the adolescents. Prevention promotion campaigns should be comprehensive, encompassing all areas in youth and family activities and should be included in the Bill.

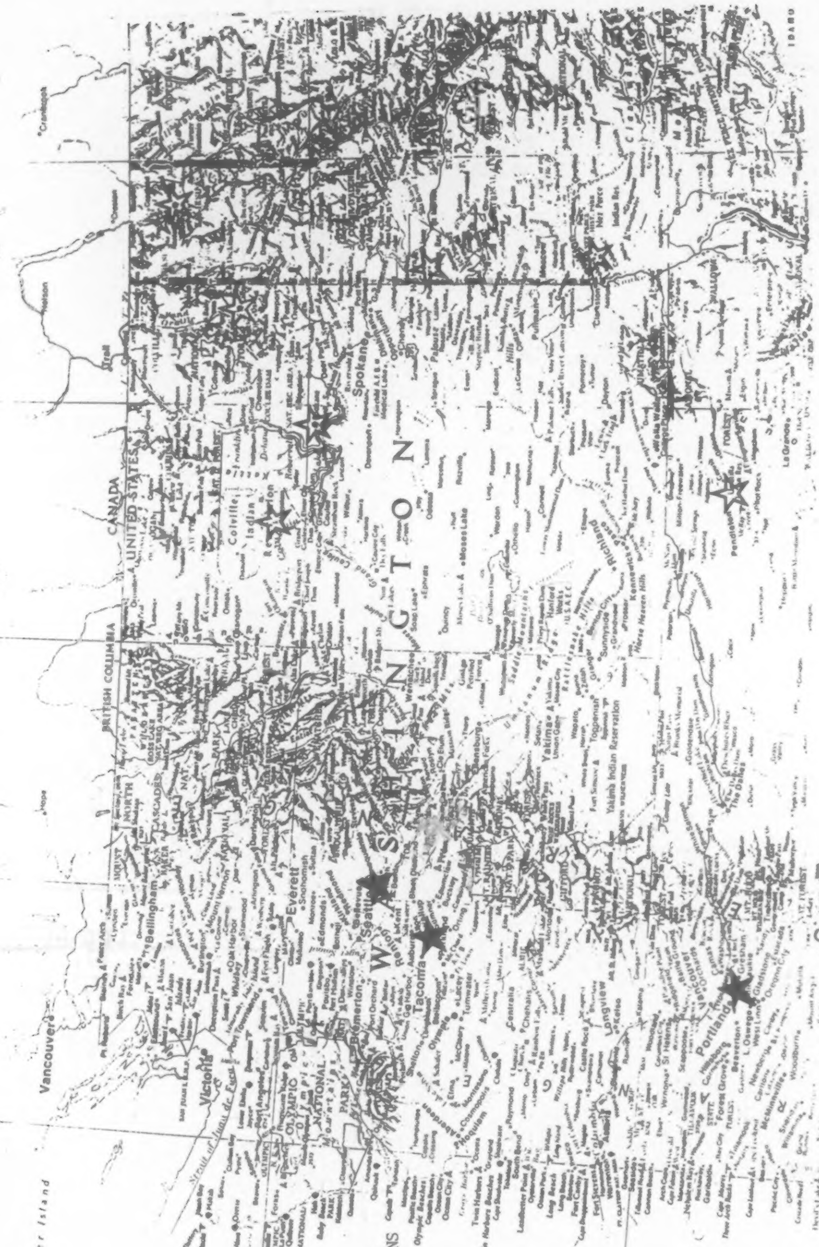
We also want you to be aware that other populations who should be under Public Health care are being treated by IHS facilities and escalating costs indentified as being American Indian. We do not object to the services and care being provided, but feel that their costs should be separated and appropriated accordingly.

PL 99-570 authorizes programs to address the alcohol and drug related problems. The purpose of Exhibit E is to point out the lack of existing services in our area. Exhibit E also reflects that for the first time in history tribal communities and governing bodies are uniting to combat substance abuse.

In conclusion the U. S. Government mandates self determination and economic development for our Tribes and yet our people are disfunctional because of these foreign substances that have permeated even your own borders, and on into our very being.

The irony of all of this is that you as the U. S. Government banned by creation of your laws, our natural use of aboriginal plants which enhanced our spiritual and cultural peace and well-being. While on the other hand, when we ask for your assistance to wipe out the stereotype and reality of the drunken, stoned Indian, your hands on the dollars that could save our people only becomes more clenched. It is within your power to help us eradicate these alien substances.

Mr. Chairman, committee members, our Consortium thanks you for your leadership, time and attentiveness.


CANADA
BRITISH COLUMBIA
UNITED STATES
WASHINGTON
Vancouver Island
Vancouver
Victoria
Seattle
Tacoma
Everett
Spokane
Portland
Vancouver
PACIFIC
OCEAN

☆ DENOTES INLAND TRIBAL CONSORTIUM RESERVATIONS

★ SOLID STAR DENOTES EXISTING TREATMENT FACILITY

Exhibit A

KALISPEL TRIBE OF INDIANS

June 18,1987

Mr. Norman Enyart
Indian Health Service
Portland Area
Portland, Oregon 97209

Dear Mr. Enyart:

The Kalispel Tribe needs technical assistance in developing the Tribal Action Plan as called for by the 1986 Anti-Drug and Alcohol Abuse Act. As per your suggestion we have set aside July 8 and 9 to develop guidelines, etc., for the TAP.

We hope that you will be able to join us for both days. We plan to begin the planning meetings at 9:00 a.m. at the Tribal Headquarters.

We look forward to your assistance.

Sincerely,

Dave Bonga

Dave Bonga

** The training meeting took place, but it was for one-half day and not two days. All deadlines were met but the Tribe has not recieved any input from IHS regarding the TAP, that was submitted July 20, 1987.

Dave Bonga

BOX 39 — USK, WASHINGTON 99180 — PHONE (509) 445-1147

EXHIBIT B

** The September 4th deadline was met. The Kalispel Tribe has not recieved any official response in writing from IHS. The Portland Area Office claims they have sent modifications, but neither the tribe no local IHS service unit have recieved the modifications.

Dave Bonga

KALISPEL TRIBE OF INDIANS

September 21, 1987

Mr. Don Davis - Area Director
Indian Health Service
P.O. Box 3785
Portland, Oregon 97208

Dear Mr. Davis:

The Kalispel Tribe was unofficially informed on August 19, 1987 at an Inland Tribal Consortium (ITC) meeting that the Tribe was to receive $11,500.00 under the Anti-Drug and Alcohol Act to begin an alcohol program. The information was a complete surprise to the Tribe.

In order to obtain further information regarding the grant I contacted Mr. John Mackey on August 25, 1987. Mr. Mackey responded, in a manner I consider disrespectful, that if I would check my mail I would find the information as his office had mailed the information regarding the $11,500+ three weeks before. Nevertheless the Kalispel Tribe did not receive information regarding the $11,500+ until August 27, 1987. At that time we were informed that we had to submit a proposal that had to be received by the Portland office no later than September 4, 1987, if we wanted to be considered for the funds.

The Kalispel Tribe has had similar experiences regarding other funds and information concerning the Anti-Drug and Alcohol Act. The Tribe would therefore like to voice it's dissatisfaction and concern with the method the Act has been administered by the Portland Area IHS office.

Thank you.

Sincerely,

Glen Nenema

Glen Nenema, Chairman
Kalispel Business Committee

BOX 38 • USK, WASHINGTON 99180 • PHONE (509) 445-1147

EXHIBIT B

GN/pn

** Dr. Smith did meet with the Inland Tribal Consortium, but there has been no response from Dr. Mason on an official level. Dr. Smith's meeting was on her own initiative after ITC requested her presence.

Dave Bonga

KALISPEL TRIBE OF INDIANS

July 20,1987

Mr. Bud Mason - Chief
Alcohol & Substance Abuse Program Branch
IHS - Room 6A - 53
5600 Fishers Lane
Rockville, Maryland 20857

Dear Mr. Mason:

Seven Indian tribes located east of the Cascade Mountains in the Pacific Northwest have formed an organization known as the Inland Tribal Consortium (ITC). The consortium consists of the following tribes: Colville, Spokane, Kalispel, Kootenai, Coeur d'Alene, Nez Perce and Umatilla.

The purpose behind the formation of ITC was to create an official body of tribes to work cooperatively towards the creation of a Residential Treatment Center (RTC) for reservation Indians that was located on the eastern side of the Cascade Mountains. To that end the ITC has been exploring all possible solutions to locate an RTC east of the Cascades.

The ITC has learned that Dr. Eva Smith will be in Spokane July 26-29,1987 to attend the Association of American Indian Physicians (AAIP) meeting. The ITC members have also been planning to attend the meeting. For that reason, I have been asked by ITC to contact your office to arrange a meeting between Dr. Smith and the ITC members. The Agenda for the AAIP meeting reveals that a short meeting between Dr. Smith and ITC could be held at 5:00pm on Tuesday, July 28,1987.

In addition a site for the RTC east of the Cascades has been considered by the ITC. The proposed site is located 12 miles north of Spokane. A site visit during the afternoon is currently being arranged for Dr. Smith on Wednesday, July 29,1987.

We truly hope that Dr. Smith will meet with the ITC. Therefore we look forward to a favorable reply.

Sincerely,

Glen Nenema

Glen Nenema
Kalispel Tribal Chairman

BOX 39 — USK, WASHINGTON 99180 — PHONE (509) 445-1147

Exhibit B

1987-171

RESOLUTION

WHEREAS, it is the recommendation of the Health, Education and Welfare Committee and Tribal Coordinating Committee that Indian Health Services; Portland Area Office Director be apprised that the Colville Confederated Tribes opposes the proposal for $300,000 to be channeled into Contract Health Services rather than for a regional treatment center for the Portland Area. (Memo/Testimony attached).

THEREFORE, BE IT RESOLVED, that we, the Colville Business Council, meeting in SPECIAL Session, this 2nd day of April, 1987, at the Colville Indian Agency, Nespelem, Washington, acting for and in behalf of the Colville Confederated Tribes, do hereby approve the recommendation of the Health, Education & Welfare Committee of the Business Council.

The foregoing was duly enacted by the Colville Business Council by a vote of 11 FOR 0 AGAINST, under authority contained in Article V, Section 1(a) of the Constitution of the Confederated Tribes of the Colville Reservation, ratified by the Colville Indians on February 26, 1938, and approved by the Commissioner of Indian Affairs on April 19, 1938.

ATTEST:

Andrew C Joseph
Mel Tonasket, Chairman
Colville Business Council

CC: HMoses, Jr.
MMarchand
LBourgeau
TKnapton
NMcCraigie
YMisiaszek

EXHIBIT C

COLVILLE CONFEDERATED TRIBES

Colville Reservation

Memorandum

TO: Mel Tonasket, Chairman

From: Lee Bourgeau, Coordinator
Tribal Action Plan

DATE: 3/13/87

Subject: Regional Treatment Center

Our Service Unit Director shared the first page of the PAO-Executive Committee Meeting Minutes. A copy is attached. The Executive Director directed me to prepare some testimony for you relating to this issue.

*****

The Colville Confederated Tribes takes exception to the proposal for $300,000. to channeled into Contract Health Services rather than for a Regional Treatment Center. This action would not improve alcoholism and substance abuse services for the Colville Reservation.

1. Travel: Our programs and individual clients would continue to bear the burden of travel - both availability and the cost. Patients would require transportation, because of their disease, are usually not employed nor do they own vehicles. It is a rare occasion that even their families are able to assist in any way. Our CHR, Social Services and Alcohol Programs do not have adequate budgets to provide such client support: Transportation has been a consistent encumberance on budgets and staff time.

2. The element of distance to the existing treatment facilities would not promote the involvement of the family in treatment. All substance abuse professionals know that co-dependency, and the dysfunctional roles children and spouse assume are as much a part of the disease as the actual alcoholism. The scapegoat, the caretakers, the adjuster and the clown roles a family assumes to hide and protect the alcoholic are aspects of the family disease that must be treated.

3. The closer proximity of a treatment center would allow for uninterrupted community support from intervention to rehabilitation. Experiences, such as Alkali Lake attest to the success of abstinence if significant others are involved in the recovery process.

4. Substance abuse treatment professional empirically know that spiritualism and culture are imperative in the treatment for Indian people. Our elders and spiritual leaders are not available to clients in the urban settings West of the Cascades. Coastal culture is certainly distinctly different than our local culture. Not only do our people need the support and strength of our own culture, but also need the guidance of our own spiritual leaders

EXHIBIT C

5. Allocating monies into Contract Health Services rather than a Regional Treatment Center would impede the strides the Colville Tribes have made on alcohol and drug abuse problems. The bottom line is LIVES. Our people are dying from alcoholism related health conditions and accidents, and suicides. We would remain status quo. Certainly the intent of the law, and purposes for the allocations is to improve the quality and longevity of Native American lives

The Colville Confederated Tribes does take the stand, that the $300,000. proposed to be put into Contract Health Services should go for the intended purpose, a Portland Area Regional Treatment Center.

cc Mary Marchand - HEW/TCC
Terry Knapton - Executive Director
Norine McCraigie - Acting CIAP Program Manager
Yvonne Misiaszek - Tribal Community Health Programs Manager
Kathy Desautel - Accounting - RAM Steering Committee

EXHIBIT C

1987-172

RESOLUTION

WHEREAS, it is the recommendation of the Health, Education and Welfare Committee and Tribal Coordinating Committee to convey to BIA and IHS Area Directors that training be made available at sites East of the Cascade Mountains. Further, that Tribes East of the Cascades be allowed to participate in any group that is identified to select training sites, and training topics.

THEREFORE, BE IT RESOLVED, that we, the Colville Business Council, meeting in SPECIAL Session, this 2nd day of April, 1987, at the Colville Indian Agency, Nespelem, Washington, acting for and in behalf of the Colville Confederated Tribes, do hereby approve the recommendation of the HEW/Tribal Coordinating Committee of the Business Council.

The foregoing was duly enacted by the Colville Business Council by a vote of 10 FOR 0 AGAINST, under authority contained in Article V, Section 1(a) of the Constitution of the Confederated Tribes of the Colville Reservation, ratified by the Colville Indians on February 26, 1938, and approved by the Commissioner of Indian Affairs on April 19, 1938.

ATTEST:

Andrew C. Joseph

Mel Tonasket, Chairman
Colville Business Council

CC: HMoses, Jr.
MMarchand
YMisiaszek
NMcCraigie

EXHIBIT D

Colville Confederated Tribes
P.O. Box 150 - Nespelem, Washington 99155 (509) 634-4711

April 1, 1987

TO: Stanley Speaks, Director BIA-PAO
Don Davis, Director IHS-PAO

FROM: Colville Business Council

RE: Alcohol and Substance Abuse IHS Training

The Colville Confederated Tribes Business Council has the responsibility for the general welfare of our tribal members. Long standing problems related to alcohol and substance abuse such as suicides, homicides, domestic violence, physical and sexual abuse of children, employee performance and company loss, divorce and general deterioration of families have destroyed our richest natural resource, our people. The Colville Business Council has given top priority to the reduction of alcohol and substance abuse, and is aggressively pursuing all available resources in this endeavor.

The Indian Alcohol and Substance Abuse Prevention and Treatment Act monies will not adequately address the intensity of the needs on our reservation. Our programs and individual staff have had to bear the burden of travel and costs to attend the training that IHS has made available. The schedule of IHS trainings for FY 86-87 reflects the continued encumberance on our tribe, with only one training planned at a site East of the Cascade Mountains.

In the spirit of Indian Self-Determination, the Portland Area Tribes know their specific training needs, are cognizant of competent professional trainers, and consequently should be involved in the planning of these trainings.

Training notices have not been recieved on a timely basis to allow time for planning travel, programmatic coverage for our staff to participate in the trainings. These concerns are shared by schools and agencies that serve our Indian people.

Also, a request has been directed to our BIA Agency Superintendent, and he in turn has asked for technical assistance monies to fund the coordination of our comprehensive and complex planning of our Tribal Action Plan. To date we have no response from BIA.

A cohesive and holistic approach must be taken in our battle on alcohol and drug abuse. Please consider these concerns in your decisions and planning related to the Indian Alcohol and Substance Abuse Prevention and Treatment Act.

Respectfully,

Andrew C. Joseph
Mel Tonasket, Chairman
Colville Business Council

cc Agency Superintendent
Service Unit Director

EXHIBIT D

MT MM lb

EXHIBIT D

PORTLAND AREA SUBSTANCE ABUSE TRAINING PLAN FISCAL YEAR 86-87

TOTAL.

FEBRUARY
2ND QUARTER
• PRIMARY (A)
PORTLAND
TOPIC: YOUTH AND DRUGS (PREVENTION AND TREATMENT)
DATE: 10, 11, 12, & 13 FEBRUARY, 1987
SITE: PORTLAND, OREGON
THUNDERBIRD — VANCOUVER
COST:

JUNE
3RD QUARTER
• PRIMARY (B)
TACOMA
TOPIC: YOUTH AND DRUGS (PREVENTION AND TREATMENT..Con't)
DATE: 9, 10, 11 & 12 JUNE, 1987
SITE: TACOMA, WASHINGTON
SHERWOOD INN & BLAKE ISLAND
COST:

SEPTEMBER
4TH QUARTER
• PRIMARY (C)
SEATTLE
TOPIC: FAMILY AND DRUGS (YOUTH)
DATE: 11, 12, 13, & 14 AUGUST, 1987
SITE: SEATTLE, WASHINGTON
DOUBLE TREE INN & BLAKE ISLAND
COST:

(1) TACOMA
SPECIAL TRAINING
TOPIC: AFTERCARE RESPONSIBILITIES
DATE: 4, 5, & 6, MARCH/87
SITE: TACOMA, WASHINGTON
SHERWOOD INN
COST:

(2) SEATTLE
SPECIAL TRAINING
TOPIC: PREVENTION
DATE: 8, 9, & 10, APRIL/87
SITE: DOUBLE TREE INN
COST:

(3) SPOKANE
SPECIAL TRAINING
TOPIC: TREATMENT AND PREVENTION YOUTH DRUG ABUSERS
DATE: 8, 9, & 10, JULY/87
SITE: SHERATON INN
COST:

(4) TULALIP
SPECIAL TRAINING
TOPIC: NETWORKING AND RESOURCE UTILITIES
DATE: 26, 27, & 28 AUGUST/87
SITE: TO BE SELECTED
COST:

(5) PORTLAND
SPECIAL TRAINING
TOPIC: ASSESSMENT AND TREATMENT PLANNING FOR CHEMICAL ABUSE - YOUTH
DATE: 23, 24, & 25 SEPT./87
SITE: PORTLAND, OREGON
COST:

Exhibit E

INLAND TRIBAL CONSORTIUM

TRIBE	Juvenile Delinquent Code	Juvenile Detention Center	Local Medical Clinic	Tribal Police Dept.	Tribal Mental Health	Tribal Alcohol Program	CHR's	Tribal Probation Program	Community Input	Is Community Supportive	Is Council Supportive
Nez Perce	Yes	no	yes	no	yes	yes	yes	no	yes	yes	yes
Coeur d' Alene	no	no	yes	BIA	yes	yes	yes	no	yes	yes	yes
Kalispel	no	no	no	county	no	no	yes	no	yes	yes	yes
Kootenai	no	no	no	no	no	no	yes	no	yes	yes	yes
Spokane	no	no	yes	BIA	no	yes	yes	no	yes	yes	yes
Colville	no	no	yes	yes	yes	yes	yes	yes	yes	yes	yes
Umatilla	yes	no	yes	yes	no	yes	yes	State	yes	yes	yes

** POLL TAKEN 10/30/87 IN SPOKANE, WASHINGTON

KALISPEL TRIBE OF INDIANS

September 21, 1987

The Honorable Thomas Foley
1201 Longworth H.O.B.
Washington, D.C. 20515

Dear Congressman Foley:

The Kalispel Indian Tribe would like to inform your office of the Tribe's dissatisfaction with the implementation of the 1986 Anti-Drug and Alcohol Act by Indian Health Service and Bureau of Indian Affairs for the Kalispel Tribe.

Information regarding the availability of programs and funds under the Act has been slow and erratic. In addition it is the Tribe's belief that the Portland Area Office for IHS and BIA have failed to constructively consult with Tribe's for their input. This has resulted in Tribal programs that have been hastily developed to meet requirements and standards that have been established by the Portland offices.

The Tribe does not believe that Congress wanted the implementation of the Act to be so inefficient and lacking of Tribal input.

Thank you.

Sincerely,

Glen Nenema

Glen Nenema, Chairman
Kalispel Business Committee

GN/pn

BOX 38 • USK, WASHINGTON 99180 • PHONE (509) 445-1147

Exhibit B

Testimony before

The Senate Select Committee on Indian Affairs
on the implementation of Public Law 99-570

THE ALASKA NATIVE HEALTH BOARD

THE ASSOCIATION OF REGIONAL HEALTH DIRECTORS

THE ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION

THE BRISTOL BAY AREA HEALTH CORPORATION

THE COPPER RIVER NATIVE ASSOCIATION

THE KODIAK AREA NATIVE ASSOCIATION

MANIILAQ ASSSOCIATION, THE NORTH PACIFIC RIM

THE NORTH SLOPE BOROUGH, THE SOUTHCENTRAL FOUNDATION

THE NORTON SOUND HEALTH CORPORATION

THE SOUTHEAST ALASKA REGIONAL HEALTH CORPORATION

THE TANANA CHIEFS CONFEREENCE AND

THE YUKON-KUSKOKWIM HEALTH CORPORATION

Presented by:

Kenneth B. Charlie
Chairman
Alaska Native Health Board
Member, The Tanana Chiefs
Conference

November 5, 1987

TESTIMONY BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

Mr. Chairman and members of the Committee, my name is Kenneth Charlie and I am the Chairman of the Health Committee of the Tanana Chiefs Conference, a tribal organization serving the health and social service needs of the Alaska Native people in Alaska's vast interior region. I am also the Chairman of the Alaska Native Health Board, a statewide consumer organization established to champion the health care needs of Alaska's Native people. I am testifying today on behalf of the Alaska Native Health Board, as well as on behalf of the Alaska Association of Regional Health Directors and its member tribal organizations.

In Alaska we have a very special interest in Public Law 99-570. Alaska Natives suffer the results of alcohol and drug abuse as perhaps no other people on this continent. The single greatest cause of death and suffering in Alaska is injuries. Among the Native population, an estimated 85% of those injuries are related to alcohol and drug abuse. For all races in Alaska, alcohol is involved in 64% of homicides, 79% of violent felonies, and 77% of domestic violence incidents. The rate for fetal alcohol syndrome (FAS) in Seattle is 1.7 per 1000 live births, and 2.0 per 1000 live births on the Navajo Reservation. Sadly, the overall rate for FAS among Alaska Natives is 4.2 per 1000 live births, with some communities as high as 12 per 1000 live births.

There is no question that Public Law 99-570 has the potential for impacting dramatically upon alcohol and drug abuse in Alaska. Unfortunately, there are some problems with the law, which seriously undermined the efforts of the Bureau of Indian Affiars and the Indian Health Service to implement it. It is also our feeling that both the IHS and the BIA through their delays, lack of action and over complication of such well intentioned legislation, have hampered a potentially great self-determining health process.

PROBLEMS WITH THE LAW:

A major flaw in the law was the lack of clear coordinating authority. Several federal agencies were given a "piece" of the responsibility, but no one was given the role of "leader". This has, we feel, resulted in poor implementation from the very beginning. We would suggest that the Indian Health Service, due to its primary focus in health, be given the primary responsibility for implementing the law.

The Tribal Action Plans (TAPs) required in the law may be an exercize in futility for the tribes because of the way in which the law directs that standards and criteria are to be developed. The law stipulates that the agency's standards and criteria must be developed within the initial 120 day period. The law indicates that these are "minimum standards and criteria", but doesn't say just how minimum. Standards and criteria should flow out of the experience of the tribes and the agencies at the line level in a joint planning effort, not from the headquarters of the BIA and the IHS -- that has been precisely the problem in the administration of programs for Indians and Alaska Natives in the past. Standards and criteria designed for large urban-based programs should not be applied to small rural programs for communities of 50, 500 or even 1500 people. Applying such standards and criteria is a deliberate discriminatory and unfair practice on the part of government agencies. If the larger contractors and service units already have great difficulty in administering programs because of unrealistic, urban, non-Native designed standards, then the smaller, rural community based programs are destined for a similar failure and for the same reason.

The law provides that if a tribe has not, for whatever reason, developed a resolution or a TAP, the BIA and IHS are required to "identify and coordinate available programs and resources to carry out the purposes of this subtitle for such tribe". It is recognized that Congress, in requiring this, is acknowledging the very serious problem that alcohol abuse presents to Native people. However, the self determination part of this is so important -- communities taking responsibility for their own community-based drug and alcohol problems -- that the law should provide more liberal timeframes and substantially increased funds for development of the TAPs. The development of a TAP is itself, the first step in a rehabilitation effort, because through the TAP, the community begins to recognize the nature of its problems. Actual experience in implementing the law indicates poor coordination between BIA and the IHS at the national level, and the imposition of impossible time frames for the development of TAPs by the villages. There simply haven't been very many TAPs developed, leaving the way open for the BIA and IHS to interpret what it means to "carry out the purposes of this subtitle", thus again locking into place program directions before the tribes have even had a crack at it.

With regard to the large number of tribes in Alaska, there is a major problem in the law. 25 USC 2412, Sec.4206, (b),(1), provides for the formation of a Tribal Coordinating Committee, which is to have responsibility at the local level for implementing the provisions of the TAP. The problem is that this committee shall - "at a minimum, have as members a tribal representative who shall serve as Chairman and the Bureau of Indian Affairs agency and education superintendents, where appropriate, and the Indian Health Service service unit director, or their representatives." These membership requirements may be somewhat unrealistic in Alaska, where there are 196 tribes (and potentially that many TAPs). There will certainly not be enough service unit directors or their representatives to distribute to these Tribal Coordinating Committees. Each tribe in Alaska views itself as a sovereign entity, and each deserves a Tribal Coordinating Committee. It is simply the membership composition suggested in the Act that is unrealistic.

Another major flaw in the law is that it tends to be "single issue oriented", which is to say that most young persons who are abusing alcohol and drugs have multiple problems. To focus so intently upon the medical model, whether it be through curriculum, the courts, or the health system, is to ignore other vital aspects of the individual's life. For example, funds should be made available for vocational rehabilitation, or the potential improvement of the desperate economic conditions which underlay many of these problems. Tribes need to be able to do some strategic planning about where they want to be ten or twenty years from now, especially in terms of economic opportunities for youth. The law should be slightly refocused in order to be be less intent upon managing immediate crises rather than working toward long range solutions.

The question here is, how do we begin to deal with these multiple problems? In one case with which we are familiar, a young Yupik woman faces more than the "simple" problem of alcohol addiction. She is sixteen years of age. Her younger sister has been molested, and her brother has committed suicide. She is alcoholic. Her mother has disappeared, and she has tried to care for a drinking and abusing father. She has been in and out of foster homes, and is described by an evaluating psychiatrist as "having no emotional connection to anything or anybody in this world." This young woman has few marketable skills and a record of scholastic failure.

There is a lot more going on in the above situation (as there is in most) than simple abuse of a substance. There is certainly a question of long term economic support for the individual - there is also a question of long term mental health treatment (over and above the treatment for alcohol addiction) - there is a question of need for additional foster care (or other form of housing) and for specialized educational services. The data systems developing around these new programs need to measure in some way progress with youth in these other need areas that are in addition to caring for the primary alcohol addiction.

PROBLEMS IN IMPLEMENTING THE LAW:

The process of implementing Public Law 99-570 in Alaska has been in reverse order of Congressional intent. The law properly and appropriately focuses upon the tribal community as the important "action point", both for direction in planning and in implementing prevention and treatment programs. Alaska tribes or villages were not notified by the BIA or IHS in a timely manner of the opportunities available to them for developing Tribal Action Plans. As a consequence, both those agencies established unrealistic timelines for planning and implementing outcomes, which locked into place standards and criteria long before smaller agency and tribal units were even fully aware of the law and what it meant. In other words, both the BIA and the IHS were instructed to develop their "plans" in a way that never brought the smaller units into play. The "coordinated planning" so strongly emphasized in the law has not been and cannot be a reality within such a context. Instead, there has been strongly perpetuated the same old "benevolent paternalism" so characteristic of past governmental-Indian relations.

Thus, while the Indian communities and Native villages were supposed to "drive" the system by having them fully involved and committed through the development of tribal resolutions and plans we now have, once again, plans developed at the top, in reverse order from the intended purpose of the law itself, with the implementing agencies to impose upon the tribes standards and criteria and program directions and outcomes that are only marginally relevent and which are at best poorly understood by the tribes.

The question that was asked earlier in this context is: How appropriate was it to have so many Federal agencies involved without designating one or the other prime responsibility for the program? The response to critical local issues and unmet needs should be driven by the Tribal Action Plans, as described in the Law. The agencies simply have not shown good intent in supporting the development of TAPs over the timeframe established by Congress. The evidence speaks eloquently: Cooperation between the IHS and the BIA deteriorated seriously, resulting in this "cart before the horse" outcome that we now face.

From October 1986 through July 1987, Alaska tribes continued to be told that there would be no funds available for the development of village or regional Tribal Action Plans. The BIA Area Directors were not informed of the FY87 reprogramming of funds to perform TAPs until July 17, 1987. (Apparently, the $1 million authorized by the law for planning did not get appropriated.) The Alaska BIA Social Services section in Juneau was not notified of these funds until July 27. The Headquarters document directed the Alaska BIA to notify tribes within three days (by July 31) that the funds were available. Almost a whole year of opportunity was lost for tribes to develop TAPs and begin activities as planned. Funds to support TAPs efforts were the last to be distributed -- after decisions had already been made as to how the program funds would be spent and by whom. Existing precious Native health program resources were diverted as the regioinal 638 tribal contractors attempted to shore up the planning effort with other funds, in order to comply with the law.

Interestingly, the $258,600 that was made available for TAPs in Alaska did not become availiable for assisting the tribes in writing their TAPs until around the 1st of August -- long after the IHS and BIA Areas were instructed to develop their Area plans. Additionally, and mysteriously, the BIA listed the number of tribes in Alaska to develop TAPs as 68, not the 196 tribes that the BIA typically recognizes in Alaska. Incidently, while Alaska tribes account for about 1/2 of the total number of BIA recognized tribes in the United States, only 1/4 of the funds identified for developing TAPs was intended for Alaska, or the approximately 220 village TAPs that IHS in Alaska now feels must be secured to fully implement Public Law 99-570.

We have heard that the Administration does not believe that the follow-on two years of planning funds is needed. Nothing could be further from the truth. First, this planning money was supposed to (for the first time) allow planning at the lowest level, the small tribal unit and the village, where planning funds have not typically been available. Second, in Alaska, where there are 196 tribal units eligible to produce TAPs, and where there is very little direct experience in health planning, the $258,600 is simply not enough to do that job. There are an additional 25 tribal communities that are regularly served by the Indian Health Service, but which are not recognized by the BIA in Alaska.

THE PROBLEM OF "LESS" BIA IN ALASKA:

In Alaska, the entire BIA involvement has been crippled because of the lesser presence of that agency here than in other areas of the country. For example, there was no funding in Alaska for the tribal courts or education aspects of the law. This, even though tribal courts are tremendously active in Alaska, and they are especially active in alcoholism and drug problems as they relate to children's proceedings which come up in front of the tribal courts (i.e., foster care, custody and adoption). Also, the half-way houses and emergency shelters discussed in the law simply did not receive adequate funding. The BIA Headquarters sent an announcement inviting competitive applications for construction of half-way houses and emergency shelters to tribes in their "Tribal Leader" newsletter back in June -- at a time when the tribes still didn't really know very much about the new law. Understandably, there were no applications from Alaska for these construction funds.

ALASKA HAS THE MOST SEVERE ALCOHOL PROBLEM IN THE NATION:

The allocation process does not sufficiently recognize Alaska's more severe problem. By every measure of alcohol abuse one can contrive, Alaska suffers more than other parts of the country. This is true for all races in Alaska, which boasts the dubious distinction of having the highest per capita consumption of alcohol in the world. (Note: the abuse of alcohol in polar and northern regions of the world tend generally to be greater than in temperate and tropical regions). Simply stated, Alaska has ended up with a small fraction of what is needed to address the problem and far less than other parts of the Country received. This fact is shocking when you consider that the severity of the alcoholism and drug abuse problem in Alaska is worse than anywhere else. The Act should have been drafted to steer proportionately greater funds to Alaska, not fewer.

P.L. 99-570 SHOULD FOCUS ON THE VERY YOUNG:

Public Law 99-570 served the very important function of shifting society's focus from chronic adult to youth. That focus needs to be shifted even more, to deal with the problems of alcohol abuse as it relates to fetal alcohol syndrome, and to early childhood development. There should be more activity with day care and other early childhood programs, such as Head Start. Public Law 99-570 should be more forthright in establishing these earlier target age groups.

YOUTH TREATMENT

On the question of construction of a Youth Treatment Facility in Alaska, the amount established at IHS headquarters, $750,000, is totally inappropriate in terms of what it costs to do business in Alaska. Alaska is an enormous place, with extremely high construction and operating costs. Ideally, there would be a treatment facility in each of the twelve geographic regions of the state. However, recognizing the poor likelihood of ever securing enough funding for such outlays, the collective tribes of Alaska have said that three treatment locations, or "nodes", situated in Sitka, Anchorage and Fairbanks, would function adequately.

Mr. Chairman and Members of the Committee:

I am Dr. Everett Rhoades, Director of the Indian Health Service (IHS). I am accompanied by Dr. Craig Vanderwagen, Director, Division of Clinical/Preventive Services; Russell Mason, Chief, Alcohol/Substance Abuse Program; and Dr. Eva Marie Smith, Medical Adviser for Alcohol/Substance Abuse. We are pleased to be here today to discuss with you our efforts to implement the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, Subtitle C of Title IV of Public Law (P.L.) 99-570.

The IHS is the Federal entity charged with administering the principal health program for American Indians and Alaska Natives. The goal of the IHS is to raise the health status of American Indian and Alaska Native people to the highest possible level. Its mission is threefold: 1) to provide and/or assure the availability of high quality, comprehensive, and accessible health services; 2) to provide increasing opportunities for Indians to manage and operate their own health programs; and 3) to serve as a health advocate for Indian people. In Fiscal Year 1988, the IHS will continue its mission by providing comprehensive health services to over one million Indian and Alaska Native people.

Alcohol and Drug Abuse Program

The IHS has for years recognized alcoholism and drug abuse as a major health problem and a contributing factor to the four leading causes of death among the American Indian and Alaska Native populations. However, it was not until the passage of P.L. 94-437 and the transfer of the alcoholism program responsibility regarding Indians to the IHS from the National Institute on Alcohol Abuse and Alcoholism in FY 1978, that a major emphasis was directed at this problem. Since 1978, with limited resources, the IHS has taken aggressive steps to address this disease and its consequences.

Examples of the accomplishments of the IHS Alcoholism and Substance Abuse Program can be summarized as follows:

- The Fetal Alcohol Syndrome (FAS) prevention training project conducted training at 68 sites (Service Units) with a total of 1,451 participants trained from 1980 to 1985. Using the training of trainers concept, these 1,451 individuals will, in turn, provide FAS prevention training within their individual communities.

- A Management Information System, the Alcoholism Treatment Guidance System (ATGS), has been in place for several years and has been refined to provide protocols for diagnosis and treatment planning, management information and to provide for quality assurance.

- The development of a Primary Care Provider's alcoholism and substance abuse training package for clinicians was completed during FY 1987. To date, 172 IHS Primary Care Providers have been trained.

The publication of a document on findings of the IHS School and Community-Based Alcoholism and Substance Abuse Prevention Survey was recently released. This survey specifically identified positive alcoholism and substance abuse prevention/intervention activities aimed at American Indian/Alaska Native youth. A follow-up on the impact of these activities will be forthcoming.

A major ongoing effort has been the integration of the alcoholism program initiatives into the overall IHS tribal health care delivery systems in order to deal with the full spectrum and complexity of alcoholism and substance abuse.

As part of this effort, the alcoholism program was reviewed by IHS program officials and tribal representatives in FY 1985. The recommendations from the review led to a restructuring of the substance abuse efforts of IHS. Specifically, prevention services aimed at youth, rather than a predominance of treatment services for older alcoholics, became the primary focus of the program activities.

Secretarial Initiative

As a result of Secretary Bowen's recognition of the alcoholism and substance abuse problem in 1986, he directed the PHS to establish an interagency Indian Alcoholism Prevention Initiative. The inter-departmental task force subsequently negotiated four Memoranda of Agreement (MOA) between the IHS and the Office of Human Development Services (Administration on Aging; Administration for Native Americans; and Administration for Children, Youth and Families); the Alcohol, Drug Abuse and Mental Health Administration (National Institute of Mental Health; National Institute on Alcohol Abuse and Alcoholism; National Institute on Drug Abuse; Office of Substance Abuse Prevention); the Office of Minority Health and the Centers for Disease Control. Under the agreement, the agencies and offices will provide their expertise and available resources to combat alcohol and substance abuse especially among Indian youths. These efforts have expanded considerably the availability and coordination of all available departmental resources to address substance abuse in American Indian and Alaska Native communities.

Implementation of P.L. 99-570

All of these efforts have been significantly enhanced by Subtitle C of Title

IV of P.L. 99-570, the implementation of which I would like to review at this time.

The initial mandate of Section 4205 requires the Secretary of the Department of Health and Human Services and the Secretary of the Interior to establish cooperative efforts between the Bureau of Indian Affairs (BIA) and IHS in order to jointly address alcohol and substance abuse in Indian communities. After consultation with tribes and briefing sessions with tribal leadership and local IHS/BIA staff, a Memorandum of Agreement was signed by the respective Secretaries, and published and distributed to tribal chairpersons in late March. The MOA included a provision for the development of an Organizational Management Action Plan outlining specific objectives and timeliness to assure ongoing coordination. This latter document was signed by Mr. Ross Swimmer, Assistant Secretary of the Interior - Indian Affairs and myself on June 19, 1987.

Section 4206 provides tribes with the opportunity to formulate Tribal Coordinating Committees, with tribal, BIA and IHS representation, to develop Tribal Action Plans (TAPs). To date at lease 85% of the tribes have passed resolutions of intent to write a plan. In communities where tribes did not begin this process, the IHS Service Unit Directors are working with the BIA to develop a plan. To date, 154 tribal action plans have been completed. It should be noted that the law mandated a deadline for resolutions of intent - not for completion of TAPS.

The IHS was instructed to develop comprehensive alcohol and substance abuse prevention and treatment programs. Each IHS Area has developed such a program, and

further coordinated activities with the BIA by completing Area specific workplans which reflect the Tribal Action Plans.

Section 4227 requires detoxification and treatment programs and community rehabilitation and follow-up services. Site selection criteria reflecting accessibility to transportation, medical, education, vocational, cultural and social service support systems was developed for the initial treatment centers. A panel of outside experts, representing national American Indian and Alaska Native health organizations and substance abuse perspectives, assisted me in reviewing 19 proposals. Two sites for the proposed treatment programs met the criteria and were capable of beginning operations with relatively little modification to meet facility and program content concerns. These sites were: 1) the Cherokee Nation of Oklahoma, using a dormitory on the Sequoyah School grounds, and 2) the Acoma-Canoncito-Laguna (ACL) hospital in the Albuquerque Area, which was selected by a committee of all tribes in the Area and will be managed by the IHS. These two treatment centers will be operational by the first of February 1988.

Of the $3 million appropriated to staff regional youth inpatient treatment centers, $1.5 million was allocated for the operation of the Oklahoma and Albuquerque centers. The remaining $1.5 million was distributed to the remaining IHS areas, according to need as determined by alcohol-related mortality in terms of Years of Premature Life Loss (YPLL). More than 175 youths have received treatment or were assessed and are awaiting treatment at non-IHS facilities.

Community-based rehabilitation and aftercare services are presently being provided in most Indian/Alaska Native Communties through 638 contracts or IHS Service Units. Funds were distributed to Areas utilizing a formula that included YPLL, demand for services, and data on treatment effectiveness. Regional intervention teams have yet to be hired; however, position descriptions have been written. Most Areas are advertising to staff these positions which will provide technical assistance to community based programs and will assure appropriate admissions, discharges and aftercare planning for those referred for residential treatment.

Appropriations of $3.5 million were provided for Section 4228, community education and staff training. These funds were distributed to Areas based on a formula of population, YPLL and demand for prevention services in FY 1986.

In FY 1987, approximately 5,000 people were trained, including physicians, nurses, alcoholism program staff, health educators, social workers, BIA/Tribal law enforcement and educators. Education and training of tribal leaders is also occurring.

An additional $500,000 was targeted for at least one health promotion/disease prevention program. A competitive process was announced in June 1987, and 82 proposals were received. A panel selected 10 projects with funding levels averaging $50,000. The awards to each of these projects has been made. A variety of programs, including cancer prevention, teen health, smokeless tobacco, alcohol and substance abuse issues will be supported. The proposals reflect a variety of approaches depending upon local determination of greatest need.

As required, $200,000 was allocated to the Navajo Tribe for the development of an adult treatment program in Gallup, New Mexico. The Navajo Tribe, through its legislative procedures, is processing the $200,000 in P.L. 99-570 funds for this program. The Tribe will issue a Request for Proposals and already has had informal inquiries from interested parties in the Gallup community. The proposals will be for a demonstration project on approaches for breaking the cycle of alcoholism that is being observed in Gallup.

Comprehensive tribal report guidelines, reflecting all available community alcohol and drug abuse data, are also being developed. These guidelines will enable tribes to better understand the scope of the problem at the local level and to monitor progress annually.

As previously noted, the Alcoholism Treatment Guidance System enables us to track treatment and prevention services, including community education and to measure outcomes. The system will be used to track all P.L. 99-570 mandated activities, thereby increasing the ability for closer management of the designated programs.

Finally, it is my conviction that when the communities take responsibility for their own wellness, especially as it relates to alcoholism and substance abuse, IHS and other efforts in the provision of resources and expertise will have a far greater benefit. I am encouraged by the influence that P.L. 99-570 has had on many tribal communities in bringing this philosophy to bear. That ends my prepared statement. We will be happy to answer any questions you may have.

INDIAN HEALTH SERVICE
(Dollars in thousands)

	FY 1987 Appropriation	FY 1988 President's Budget
Hospitals & Health Clinics	$489,001	$461,142
Dental Services	26,450	26,684
Mental Health	11,602	11,738
Alcoholism	27,709	26,414
Maintenance & Repair	9,025	9,025
Contract Health Care	183,739	146,090
Subtotal, Clinical Services	747,526	681,093
Sanitation	22,784	23,307
Public Health Nursing	13,191	13,659
Health Education	3,961	4,008
Community Hlth. Reps.	26,000	24,191
AK Hepatitis/Immunization	395	395
Subtotal, Preventive Hlth	66,331	65,560
Urban Health Projects	9,000	8,000
Indian Health Manpower	7,018	4,646
Tribal Management	2,709	749
Direct Operations	37,111	34,337
Total, Indian Health Services	869,695	794,385

STATEMENT OF HAZEL ELBERT, DEPUTY ASSISTANT SECRETARY FOR INDIAN AFFAIRS (TRIBAL SERVICES), DEPARTMENT OF THE INTERIOR, BEFORE THE SELECT COMMITTEE ON INDIAN AFFAIRS, UNITED STATES SENATE, ON THE IMPLEMENTATION OF PUBLIC LAW 99-570-THE ANTI-DRUG ABUSE ACT OF 1986, SUBTITLE C - INDIANS AND ALASKA NATIVES.

November 5, 1987

Good day Mr. Chairman and members of the Committee. I am pleased to be here today to discuss the implementation of the Indian portion of the Anti-Drug Abuse Act of 1986 (P.L. 99-570).

Subtitle C of Title IV of the Anti-Drug Act of 1986 is designated as the "Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986" and provides for the coordination of resources through inter-agency memorandum of agreements, detailed reporting systems, a newsletter and training at all levels. The law also required BIA and IHS to work closely with the tribes to develop tribal action plans to coordinate resources and programs related to alcohol and substance abuse prevention and treatment. Tribal action plans could include establishment, funding, licensing, and operation of emergency shelters or half-way houses for Indian youth who are alcohol or substance abusers. BIA in consultation with IHS is to develop standards by which emergency shelters shall be established and operated.

Subtitle C also authorized the eradication of marijuana in Indian country and an appropriation of $500,000 for three years for the investigation and control of illegal narcotics traffic on the Tohono O'odham Reservation. The Secretary of the Interior is directed to construct or renovate new or existing juvenile detention centers and provide for the development of a Model Indian Juvenile Code.

In addition, Subtitle B of Title IV of the law reserves one percent of the amounts appropriated under the Act for Indian youth programs to meet the needs of Indian children on reservations serviced by elementary and secondary schools operated for Indian children by the Department of the Interior. This subtitle also requires all BIA schools to include as part of their curriculum, a program of instruction relating to alcohol and substance abuse prevention and treatment and allows for more flexibility of BIA facilities and funds to be used for such programs.

The FY 1987 Continuing Resolution (P.L. 99-500) included the "Omnibus Drug Supplemental Appropriations Act of 1987". Approximately $200 million was appropriated for Federal assistance to States for programs of drug abuse education and prevention. The one percent set aside for Indians was approximately $2 million. $22,500,000 was appropriated to the BIA to be used in very specific categories, some of which did not coincide with the direction given to the BIA under the Drug Act.

We requested a reprogramming of $2.5 million which was approved by the Congressional Appropriations Committee to allow us to meet more of the mandates of the Drug Act. A copy of the reprogramming letter is attached to my written statement.

Also attached to my prepared statement is a detailed chart showing the requirements of the law and the current status of implementation. Today I would like to focus on just a few of our efforts and accomplishments of this first year and discuss where we believe this effort is taking us in the future.

As we began to implement this Act, we acknowledged that substance abuse is an individual problem that could best be solved by the individual within the context of his or her own community. Our operating philosophy is that problem-solving actions must come from local people who are helping themselves or others. We see the tribal government as the primary agent to provide local assistance through the tribal action plans. The BIA's role is one of facilitator. That is, information and technical assistance will be provided as requested to tribal governments as they develop and implement their individual plans.

The tribal response has been commendable. As of October 23 1987, a total of 280 tribes had passed tribal resolutions to develop a tribal action plan (TAP). In Alaska, four corporations and 17 villages have passed TAP resolutions. To date, 128 tribes and villages have completed a TAP and are now in the process of implementing their plans.

Early in our implementation efforts we decided that many of the small tribes and villages needed some type of funding support to assist them in developing their plans. While this option was provided under the Omnibus Drug Act, no funding was appropriated for this purpose at that time. Consequently, part of our reprogramming request included $1 million to distribute to small tribes and villages using the criteria for small core management grants under 25 CFR 278. Using this criteria, a total of 263 tribes and villages received funding for the development of a TAP. A list of the funding distribution is attached to my statement.

As required in the Omnibus Drug Act we have been working closely with IHS and are operating under a Memorandum of Understanding which outlines the responsibilities of each agency in implementing parts of P.L. 99-570. We have established a network of IHS and BIA Coordinators to work with tribal counterparts and other Federal agencies to coordinate resources and effectively disseminate information. We are pleased with the progress and dedication of these teams and are confident they will continue to mobilize the effort of confronting this serious problems in our local communities in Indian country.

All of the 181 BIA funded schools received funds to develop and implement an Alcohol and Substance Abuse curriculum. The funds were distributed on a formula basis with a base amount of $10,000 for each school and an additional amount based on the amount of funds generated under the Indian School Equalization Formula for each school. Basic guidelines were developed for the development and implementation of the Alcohol and Substance Abuse curriculum. The BIA entered into a contract with the Navajo tribe in August, 1987, in the amount of $1.2 million, to develop and implement a K-12 grade substance abuse and alcohol prevention curriculum for all BIA funded schools on the Navajo reservation. The contract is for 24 months. In conjunction with the development of the curriculum, the Navajo tribe will collect data to determine the effectiveness of the curriculum and will provide appropriate training to teachers and parents concerning the use of the curriculum. The curriculum produced will also be made available for review by public schools.

The BIA funded schools located in other locations have either adopted a curriculum or are developing curricula. The majority of schools were unable to use the funds prior to the close of school last May and are now in the process of spending them.

Staff training is an integral component of any curriculum. In addition to local training, the BIA has conducted seven centralized training programs; a total of 480 personnel attended these sessions. We are currently assessing all of the schools' progress and will be evaluating the success of those training efforts throughout the school year.

In addition to the curriculum program, all BIA schools were allotted funds for counselor training. The funds again were distributed on a formula basis with a base amount of $6,000 for each school with an additional amount based on the amount of funds generated under the Indian Student Equalization Formula. Guidelines have been developed and sent to each school for the use of these funds. During the first year of implementing the Act the BIA has hired 18 alcohol and drug abuse counselors, trained 48 other school counselors, and provided training to 529 other staff members.

The Department of the Interior and the Department of Education entered into A Memorandum of Agreement on August 14, 1987 which describes how the two Departments will cooperate to meet the needs of Indian children. Under the Agreement funds will go directly to all BIA funded schools to be used for alcohol and drug prevention programs. Regulations are being developed to guide the use of these funds.

Under the construction program, $5 million was appropriated for emergency shelters, and $7.5 million was appropriated for juvenile detention centers. We have been working to establish criteria for the planning, design, construction, and/or renovation of emergency shelters or half-way houses. Thus far, 53 applications have been received for such projects. Site selections are expected to be determined by December 30, 1987.

$500,000 has been distributed to the Tohono O'odham Nation for the investigation and control of illegal narcotics traffic on their reservation, and a program for eradication of marijuana cultivation in Indian country has been established. Eradication work has been completed in areas of the Northwest, in Oklahoma, and in North Carolina.

A draft model code has been prepared and distributed to Tribal court personnel for review. This code is consistent with the Juvenile and Delinquency Prevention Act of 1974 and will be revised to reflect the comments received.

We have also established Child Protection Teams composed of BIA, IHS Tribal and State personnel who are charged with the responsibility for providing child protective services. Guidelines have been sent to all BIA, IHS and Education Program managers for the development of the teams. Most BIA Area Offices received $40,000 for Child Protection Team training.

We believe we have addressed all of the requirements of P.L. 99-570 and have set many positive actions in place. We are also working on an interagency effort for an American Indian/Alaska Native Youth Conference to be held in the spring of 1988 in Phoenix, Arizona and we are participants on the Prevention/Education and the High-Risk Youth Subcommittees of the White House National Drug Policy Board.

All of the efforts discussed today represent the serious commitment of the Department of the Interior to implement P.L. 99-570. To continue these efforts we have outlined the following areas of focus for the coming year:

1. Establish permanent access with other Federal agencies to establish a data base and provide information monthly to all Tribes, BIA and IHS offices.

2. Provide assistance to tribes to locate and access available resources to implement their TAPs.

3. Outline prevention actions that will be targeted to the American Indian and Alaska youth population, such as the 1988 youth conference.

4. Work with the National Drug Policy Board to review and streamline existing programs.

5. Institutionalize the BIA responsibility for employee sobriety and drug-free workplaces by establishing standard performance elements for managers that not only reflect individual requirements but also provide guidance in abuse situations through the application of meaningful Employee Assistance Programs.

The problems of drug and alcohol abuse in Indian country are staggering but we believe that we are on the right track in assisting the Tribes to focus on the problems in their communities and to develop appropriate plans to combat the problems.

This concludes my prepared statement. I would be happy to answer any questions the Committee may have.

Attachments

Honorable Robert C. Byrd
Chairman, Subcommittee on Interior
and Related Agencies
Committee on Appropriations
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

We propose to reprogram $2,500,000 of the $4,600,000 appropriated under the Omnibus Drug Supplemental Appropriations Act of 1987 (P. L. 99-591) to more effectively implement the provisions of the Anti-Drug Abuse Act of 1987 (P. L. 99-570). We propose to use these funds to support development of Tribal Action Plans (TAPs), to eradicate sources of drugs, and to meet other requirements associated with the Act, including staff costs, newsletter publication, and community training and education. As shown in the enclosed reprogramming summary, funds would be derived from a portion of the amounts originally earmarked for law enforcement and judicial training.

First, we propose to reprogram $1,000,000 for the development of TAPs. No funds were provided for this vital cornerstone of the Bureau's drug prevention program. We believe that the success of the anti-drug abuse effort hinges on the commitment to prevention at the local level. Tribal involvement in the drug prevention activities will help foster such a commitment, with TAPs providing the initial impetus.

Many tribal governments, particularly larger tribes, within either their own tribal resources or due to greater access to available programs and resources from other sources, have initiated plans and actions addressing local substance abuse without financial assistance from BIA. However, many smaller Indian tribes with memberships under 1,500 enrollment do not have tribal resources nor access to other resources. Without adequate resources, these smaller tribes have little capability or incentive for taking the initiative in developing an action plan that will lead to substantive results.

The requested $1,000,000 for TAPs will be directed to the smaller Indian tribes and Alaska Native communities needing financial assistance to initiate the TAP development process with maximum amounts and criteria used for approving TAP grants based upon the guidelines established in Section 102 of P. L. 93-638, the Indian Self-Determination and Assistance Act, for tribal Core Management Grants.

The Bureau also proposes to provide $1,000,000 for source eradication in order to implement Section 4216 of the Anti-Drug Abuse Act. This Act seeks to reduce both supply and demand problems. Special projects conducted by the Bureau in FY 1986 identified marijuana problems on reservations in California, Oregon, Washington and North Carolina. The reprogramming request will expand on the FY 1986 efforts to eradicate marijuana supplies on reservations and interdict trafficking of illegal processed drugs.

Additionally, $340,000 is proposed to meet the administrative and staff needs required under Section 4207 of the Anti-Drug Abuse Act. This section requires the BIA to establish and staff an Office of Alcohol and Substance Abuse. Since the initial functional responsibility is to develop strategies and plans to begin the implementation of the Act, a temporary office has been established during FY 1987. After initial implementation activities are concluded, responsibilities will be absorbed within existing programs. The requested reprogramming will provide funding in the amount of $70,000 for temporary staffing (2 FTEs) for coordination of Alcohol and Substance Abuse Implementation. Task Force implementation costs are expected to be $30,000. Additionally, $120,000 will be evenly distributed to the twelve BIA Area Offices for use in coordinating implementation actions at agency and tribal levels. Also, $120,000 will be used to cover costs of an information clearinghouse function, training of area/agency coordinators, and a quarterly newsletter to report on Indian alcohol and substance abuse projects and programs.

Pursuant to Section 4228 of the Anti-Drug Abuse Act, it is also proposed to reprogram $160,000 to develop and implement cooperatively with the Indian Health Service (at the local agency level) a program of community education. The objective will be to provide timely and concise training to community leaders of each tribal and Alaska native community.

The source of funds for this reprogramming is $2,500,000 originally provided for BIA law enforcement and judicial training. A second quarter review and analysis of training needs indicates that a total of $1,500,000 is sufficient to fully meet training requirements in FY 1987. These funds, combined with available resources, will provide training for law enforcement and judicial personnel in the investigation and prosecution of offenses related to illegal narcotics, and in alcohol and substance abuse prevention and treatment with special emphasis on youth.

This reprogramming request is intended to more effectively direct the funding toward meeting needs associated with the Anti-Drug Abuse Act. All of these reprogramming actions are intended to meet one-time needs.

This proposal is being transmitted in accordance with the agreement and understanding the Department has with the Senate and House Committees on Appropriations in regard to reprogramming of funds. If we do not receive a response from the Committee within 30 days of receipt of this letter, we will proceed with the reprogramming.

An identical letter is being sent to the Honorable Sidney R. Yates, Chairman, Subcommittee on Interior and Related Agencies, Committee on Appropriations, United States House of Representatives.

Sincerely,

SECRETARY

Enclosure

REPROGRAMMING SUMMARY

Activity	Current Funding	Proposed Funding	Change (+ or -)
Proposed Decreases			
Law Enforcement Training	$3,000,000	750,000	- 2,250,000
Judicial Training	1,000,000	750,000	- 250,000
Proposed Increases			
Tribal Action Plan Grants	- 0 -	1,000,000	+ 1,000,000
Marijuana Eradication	- 0 -	1,000,000	+ 1,000,000
Administrative Requirements	- 0 -	340,000	+ 340,000
Project Office:			
Alcohol and Substance Abuse Implementation (2 FTEs)	- 0 -	(70,000)	(+ 70,000)
Task Force Implementation	- 0 -	(30,000)	(+ 30,000)
Area Alcohol and Substance Abuse - Area Offices	- 0 -	(120,000)	(+ 120,000)
Information Clearing House/ Area/Agency Coordinator Training and Newsletter	- 0 -	(120,000)	(+ 120,000)
Community Training	- 0 -	160,000	+ 160,000
No Changes			
Model Juvenile Code	100,000	100,000	- 0 -
Grant to Papago Tribe	500,000	500,000	- 0 -

NOTE: Funding for "Administrative Requirements" has been broken down into components and shown in parentheses.

PUB. L. 99-570 - TRIBAL ACTION PLANS (TAPS) GRANT FUNDING DISTRIBUTION

Area Office	Number of Eligible Tribes	Amount Available
Aberdeen	4	$ 15,200
Anadarko	16	60,800
Albuquerque	11	41,800
Billings	None	None
Eastern	14	53,200
Juneau	68	258,600
Minneapolis	20	116,000
Muskogee	8	30,400
Navajo	None	None
Phoenix	27	113,500
Portland	23	87,500
Sacramento	72	223,000
TOTAL	263	$ 1,000,000

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending Planned	BUDGET FY 87 Approp.	BUDGET FY 88 Pres Budget Request	OMAP #
	Section 4133 (1) Requires agreement between Secretary of Education and Secretary of the Interior. (See attachment #1.)					
DOE MOA	Formulate financial arrangements to meet the needs of Indian children in BIA-operated schools in relation to alcohol and substance abuse;	-MOA completed 8/14/87. (See attachment #2.)	Application guidelines are being developed by OIEP.	$1,945	1% of appropriation	
School Curriculum	(2) Include an alcohol and substance curriculum in all BIA-funded schools and BIA shall provide technical assistance at the request of school board to develop such a curriculum;	-$10,000 base amount was distributed April 22 to all schools plus an ADM based $ amount. (See attachment #3.)	OIEP is currently reviewing the status of curriculum development.	$3.0M	- 0 -	16
Incidence Reporting	(3) Not later than 120 days (February 24, 1987) after date of enactment provide for reporting of all alcohol and substance abuse incidents in BIA-operated schools;	OIEP has directed its schools to comply with incidence reporting procedures. From those schools submitting reports, OIEP has tallied the incident information. (See attached information under #4.)	OIEP will be assessing the incidence reports & providing this preliminary information to IHS for their use in preparing a report on "the scope of the problem" in Indian country.	—	- 0 -	11

OMAP = Organizational Management Action Plan

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		
				FY 87 Approp.	FY 88 Pres. Budget Request	OMAP #
School Counseling Training	(4) Provide for individual crises intervention;	-$6,000 base plus $ based on ADM distributed 4/22 to all schools.	OIEP is currently reviewing the status of school counseling training.	$2,400.	$2,400.	17
Summer School Program	(5) Provide for use, if requested, of any BIA school facility for a summer program and provide technical assistance and coordination of such program at the discretion of the school board.	BIAM issued May 1, 1987.		- 0 -	- 0 -	

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/Planned	BUDGET		OMAP #
				FY 87 Approp.	FY 88 Pres. Budget Request	
	Section 4205					
	Not later than 120 days (February 24, 1987) after date of enactment, the Secretary of Interior and Secretary of Health and Human Services shall develop and enter into a Memorandum of Agreement MOA:	The MOA was signed by BIA 2/24/87. The MOA was used to formulate a joint Organizational Management Action Plan (OMAP).	Joint IHS/BIA Swimmer/Rhoades meeting Nov. 3.			
BIA/IHS MOA	(1) In developing MOA, consult with and solicit comments from tribes, Indian individuals, Indian organizations, and professionals in the treatment of alcohol and substance abuse;	OMAP was jointly signed by IHS & BIA 6/19/87. It has 18 short-term objectives in the following subject matter areas:		- 0 -	- 0 -	1,2, & 4
				- 0 -	- 0 -	
OMAP	(2) MOA shall provide for the coordination of the BIA and IHS alcohol and substance abuse programs/resources;	1. OMAP plan 2. Area workplan process 3. TAPs/LAPs guidelines 4. MOA review process 5. Privacy Act requirements 6. Newsletter plan 7. Community Educ/Training Plan 8. Law Enf/Jud Services	1. Continued implementation of OMAP.			1
			2. Follow-up on receipt of 3 overdue Area workplans. Review and analysis of joint area workplans.			2
			Assessment report of findings and conclusions targeted for completion 11/30/87.	- 0 -	- 0 -	

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		OMAP #
				FY 87 Approp.	FY 88 Pres. Budget Request	
		9. Emergency medical assessment process. 10. Minimum standards. 11. Scope of the problem plan. 12. Resource inventory process. 13. Emergency shelters/detention center plans. 14. Tribal comprehensive report process. 15. Child abuse data collection plan. 16. Curriculum implementation, results and report evaluation plan. 17. Crises intervention counseling training outcomes/ future plan. 18. Juvenile code.				

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		OMAP #
				FY 87 Approp.	FY 88 Pres. Budget Request	
		Long-Term Objectives 1. Data systems integration 2. Prevention awareness 3. Advocacy role 4. Policy review All action plans are being implemented according to the schedule.				
Area Workplans	(3) Activities shall supplement, not supplant, ongoing programs and local actions and undertaken in accordance with P. L. 93-638 and P. L. 99-561.					

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		
				FY 87 Approp.	FY 88 Pres Budget Request	OMAP #
	Section 4206					
TAPS	Governing body of any Indian tribe, at its discretion, adopt a resolution for the establishment of Tribal Action Plans. If tribe elects not to develop TAP, BIA superintendents shall develop plan. - TAP is to assess the problem, identify available resources, establish goals and determine local actions.	*All areas except Navajo have completed the development of a resource inventory to assist in the development of a TAP. *Of 299 tribes, 228 have passed tribal resolutions to develop a TAP. In Alaska, 18 Corporations have developed TAP resolutions and of 183 villages, 11 have passed individual TAP resolutions. As of 10/7/87, 67 Tribes/Villages have developed a TAP.	The ASAPO continues to follow-up and monitor the TAP status.			3

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		OMAP #
				FY 87 Approp.	FY 88 Pres. Budget Request	
	- BIA may make grants to provide technical assistance to tribe to develop TAP.	Reprogramming letter cleared Dept. and sent to Congress 5/5/87. House approval dated 6/15/87 and Senate approval dated 7/10/87. July 17, BIA line managers were sent TAP grant guidelines and fund distributions. 262 Tribes/ Villages were eligible to receive $1 million reprogrammed $.		$1,000.0	- 0 -	

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET FY 87 Approp.	BUDGET FY 88 Pres. Budget Request	OMAP #
	Section 4207					
OASAP	Authorizes establishment of Alcohol and Substance Abuse Office, Director and Youth Officer.	°Established Project Office in October, 1987. °Established Task Forces and completed strategies and action plans. °Completed regular Hill/BIA briefings. °Completed reprogramming action for clearance. °Trained field coordinators. °Established inter-governmental outreach through 2 subcommittees of the Drug Policy Board of the White House: 1. Prevention Education (DOE) 2. High Risk Youth (OJJDP) Also provide staff support to DOI liaison to Drug Enforcement subcommittee	Membership on the Federal workplace subcommittee will be forthcoming in FY 88.	$340,000.		Long-Term Objs. 20-22

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		OMAP #
				FY 87 Approp.	FY 88 Pres. Budget Request	
		°Established mini-clearinghouse structure at SIPI. °Formulated a Youth Leadership Conference concept at an IHS/ANA/BIA meeting on 4/28/87. °Total budget is: $280,000 funded as follows: BIA - 160,000 IHS - 20,000 HHS (HDS) - 100,000 °On 9/18/87, a cooperative agreement was signed with ITCA Inc. to serve as local tribal Consortium Host for Youth Conference to be held in Phoenix, Arizona in Spring 1988. (See attachment #2: information sheet.)	°ASAPO organizational materials were completed in September and are now in the BIA system for processing. (See attachment #1.) °Options for ongoing P.L. 99-570 area responsibilities/ positions were developed at Area Coordinators' meeting 7/27 and 7/28 in Duluth, MN. °Issue papers are being finalized for submission to AS-IA for decision.	160,000. Youth Conf.		

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		
				FY 87 Approp.	FY 88 Pres. Budget Request	OMAP #
		Major inter-agency accomplishments are set forth in summaries to White House Policy Board subcommittee. (See attachment #.)				
	Section 4208 Authorizes liberal construing of existing laws and regulations to achieve purposes of P. L. 99-570.	N/A	N/A	- 0 -	- 0 -	
Building/ Supplies	Section 4209 Make available within existing laws, local Federal facilities, property, and equipment.	Interim guidelines were sent to field 5/1/87. (See attachment #1.)	Final 43 BIAM.	- 0 -	- 0 -	
Newsletter	Section 4210 Publish a quarterly newsletter to report on alcohol and substance abuse projects and programs.	Four issues have been published bi-monthly beginning February, 87 in the "Linkages." (See attachment #2.)	IHS will be awarding a contract for FY 88 to publish a quarterly newsletter.		- 0 - (IHS to fund)	6
Education Program/ Resource Inventory	Section 4211 Review educational programs providing services to Indian youth and provide this review to each tribe.	Identification of Programs was identified in the 11 Area inventories that were completed.	Completed; no further action needed.	- 0 -	- 0 -	12

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET FY 87 Approp.	BUDGET FY 88 Pres. Budget Request	OMAP #
	Section 4212					
Pilot Summer Youth Programs	Develop and implement, subject to school board approval, pilot summer youth programs.	In FY 87 and 88, ISEP funding covers regular school-year operations and summer school in certain instances.	None.	- 0 -	- 0 -	
	Section 4213					
Youth Shelters/ Half-way Houses	Planning and design, construction and renovation, and operation of emergency shelters or half-way houses to provide emergency care for Indian youth. Funding is to be allocated on the basis of priority of need and subject to contracting pursuant to P. L. 93-638.	Tribal leader letter was sent 5/11/87 to Tribes with a copy to Area Directors 6/87/87 concerning application criteria. As of 9/16/87, 53 Tribal applications had been received by OCM. (See attachments.)	OCM is working with Social Services to develop criteria for project selection. Target date of site selection is 12/30/87.	$5.0M (no-year $)	$5.0M	13
	Section 4214					
Child Abuse/ Neglect Data	Compile data relating to number and types of child abuse and neglect cases and assistance provided. Provide this data annually to Tribe and IHS Unit Director.	°Reporting system established. °1st monthly reports have been received for August and are being assessed by Social Services & Judicial Services.	Monthly reports will follow and be used as data base to address "scope of the problem" report being prepared by IHS.	- 0 -	- 0 -	15

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		
				FY 87 Approp.	FY 88 Pres. Budget Request	OMAP #
	Section 4215					
Law Enforcement and Judicial Services Resource/ Program Review	Review, in developing MOA, Section 4205, and in cooperation with Attorney General, Law Enforcement and judicial programs and make review available to Tribes.	Identification of programs was completed March 27 as a part of the 11 Area inventories received.	Updates in FY 88.			12
	Section 4216					
Papago	Provide assistance to Papago Indian Tribe for the investigation and control of illegal narcotics traffic on the Papago Reservation.	Funds were distributed to the Phoenix Area 4/22/87.	None.	500,000	- 0 -	N/A
Eradication	Establish a program for the eradication of marijuana cultivation within Indian country. (See attachment #1.)	Reprogramming request was approved in July. Training in marijuana eradication was provided for 24 individuals, including pilots as well as law enforcement officials at the Training Center located in Klamath Falls, OR. A number of eradication efforts have been completed in the northwest, Oklahoma & North Carolina. Rental planes were utilized as a part of this eradication endeavor.		$1.0M		

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		
				FY 87 Approp.	FY 88 Pres. Budget Request	OHAP #
	Section 4217					
Tribal Courts	25 USC 1302 is amended to increase penalties for tribal courts - jail terms up to one year and fines of $5,000. (See attachment #2.)	All areas have been directed to notify tribal court systems of change.	Program will be monitored over next year in order to determine number of tribes that amend Tribal codes.			N/A
	Section 4218					
Law Enforcement and Judicial Services Training	Establish law enforcement and judicial personnel training in the investigation and prosecution of illegal narcotics offenses and in alcohol and substance abuse prevention and treatment.	Law Enforcement Four training sessions have been completed for approximately 20 persons. (See attached #1: course outline.)	Training will continue under normal training procedures.	750,000	- 0 -	8
		Judical Services Approximately 500 Judges and 80 court personnel were trained by the NIJTC. $40,000 was provided to all areas except Sacramento and Muskogee to use for Child Protection Team training 5/87. (See attachment #2.)		750,000	- 0 -	
	Section 4219					
Emergency Medical Assessment	Establish at each Agency a procedure for the emergency medical assessment and treatment of every Indian youth arrested or detained for an offense related to or involving alcohol or substance abuse.	Interim guidelines were sent to field offices 4/30/87.	Final guidelines are being developed by the Division of Law Enforcement in consultation with IHS.	- 0 -	- 0 -	9

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET FY 87 Approp.	 FY 88 Pres. Budget Request	 OMAP #
	Section 4220					
Juvenile Detention Centers	Construct or rennovate and staff new or existing juvenile detention centers.	Juvenile Standards are nearing completion. Three tribal applications have been received under PONI program and of these, Ft. Peck and Chemawa are underway.	Will continue to review tribal applications for construction.	$7.5M	$7.5M (X year) (See attached.)	13
	Section 4221					
Model Juvenile Code	Develop a Model Indian Juvenile Code consistent with the Juvenile and Delinquency Prevention Act of 1974 and include provisions for the disposition of cases involving Indian youth arrested or detained by the BIA or tribal law enforcement personnel for alcohol or drug-related offenses.	A draft model code was developed and distributed to Tribal court personnel for review. Consultation comments were rec'd mainly recommending that "child abuse" guidelines be incorporated into the code. (See attachment #1.)	Tribal Court actions to adopt the code will be monitored during FY 88.	100,000	- 0 -	18

BIA IMPLEMENTATION STATUS REPORT
Public Law 99-570 - The Anti-Drug Abuse Act of 1986.

KEY TOPIC	BIA MANDATES	Major Actions Completed	Actions Pending/ Planned	BUDGET		
				FY 87 Approp.	FY 88 Pres. Budget Request	OMAP #
	Section 4222					
Law Enforcement and Judicial Services Data	Require the compilation of data relating to calls and encounters, arrests and detentions, and dispotition of cases by BIA or tribal law enforcement or judicial personnel involving Indians where alcohol or substance abuse is a factor. Provide this data annually to tribe and IHS service Unit Director.	Monthly reporting system has been established. Preliminary data will be used by IHS in its initial report on the scope of the problem.	Baseline data will be carefully gathered and interpreted through a cross-cutting mechanism among social services, judicial services and law enforcement programs.	- 0 -	- 0 -	15

Statement of

William J. Lennox, Jr.
Director
Drug Abuse Prevention Oversight Staff
Office of the Secretary
U.S. Department of Education

Before the

Select Committee on Indian Affairs

United States Senate

November 5, 1987

Mr. Lennox is accompanied by

Thomas M. Corwin
Director, Division of Elementary, Secondary, and Vocational Analysis
Office of Planning, Budget, and Evaluation

Opening Statement
Senate Select Committee
on Indian Affairs

Mr. Chairman and members of the Committee, I am pleased to be here today to testify on the Department of Education's efforts to help eliminate drugs from schools and to point out particularly how these efforts affect Indian youth.

Secretary Bennett has been concerned about student drug use since he became Secretary two and a half years ago. When asked by a reporter what could be done to improve our schools, the Secretary replied, "Get drugs out and parents in." We have been operating under that principle ever since. One and a half years ago, the Secretary charged a team of Department researchers with finding out what works in getting drugs out of schools. The result was Schools Without Drugs, a handbook for establishing effective school prevention programs. The book contains the basic information needed to establish a comprehensive plan for schools: policies, resources, references, curricula information, model programs, facts about illegal drugs but most of all, a plan. A plan broad enough that all communities can use it, but specific enough that it details who has to be involved: parents, school officials, community leaders, and the students themselves.

The book was hailed by many as an outstanding resource. One editor called it the "single greatest weapon in our war against student drug use." To date, 1.7 million copies have been distributed, and it has become the basis for the Department's programs. Its premise is that each community is different, and each community must assess its own prevention needs, develop its own drug use prevention program, and establish a means of monitoring it. The program, however, must be comprehensive, involving parents, school officials, law enforcement officers, community leaders and students. The validity of this approach is sustained in the research summarized in the Report to Congress on the Nature and Effectiveness of Federal, State and Local Drug Prevention/Education Programs, submitted by the Departments of Education and HHS.

The Department's programs fit this philosophy. Formula grants to Governors and State educational agencies allow wide discretion at the local level. The discretionary grant programs also allow for a great deal of latitude.

The Department has moved quickly to get funds and information into the hands of people who need them. In January, we held a conference for Governors and State educational agency representatives to explain the new law and to give them information on the grants. I have attached a list of each State's allocations for your information.

Also, following up on the guidance provided in Schools Without Drugs, we have mobilized the resources of the Education Department to assist schools and communities in the implementation of effective anti-drug programs. For the record, I have attached a summary of the Department of Education's programs. I would like to mention a few of these programs and explain how they will benefit Indian youth.

The Drug-Free Schools and Communities Act authorizes the Department to provide drug abuse education and prevention services to Indian children on reservations attending elementary and secondary schools operated by the Bureau of Indian Affairs. We have negotiated a Memorandum of Agreement with the BIA to administer the $1,945,000 appropriated for this program. Department of Education and BIA staff will jointly monitor these activities which will provide additional opportunities for coordination between our two agencies.

Based on the Memorandum of Agreement, the Bureau of Indian Affairs will be treated in general as a State educational agency is treated in the Department of Education's State and Local Grant program. Ten percent of the funds may be used by the BIA for the development of a resource center and to support the program. At least ninety percent of the funds will be distributed among the BIA and tribal schools by formula.

The Department has also initiated two grant programs administered by the Secretary's Discretionary Fund staff. The two programs focus on the development and replication of successful elementary and secondary prevention programs (Federal Activities Grants Program) and the support of training and demonstration programs at institutions of higher education. In administering these two programs, we targeted Indian groups last year for the mailing of the grant announcements. We made a presentation at the National Indian Education Association meeting and put the participants interested in receiving grant announcements on our mailing list. We also worked with the Administration for Native Americans in HHS, since they also have a drug education and prevention program for Indian tribes, and that office mailed our announcements to their tribal participants. Finally the Bureau of Indian Affairs mailed our announcements to their 12 Area Offices so that they could inform the tribes in their areas of our grant competitions.

To get the information on the higher education grant program to the American Indian Tribal Colleges, we sent several packages of grant announcements to the American Indian Higher Education Consortium, and we again used the Administration for Native Americans' mailing list.

To reach the Indian elementary and secondary schools, we worked with the five Indian Education Resource and Evaluation Centers. The Centers were all sent copies of the announcements, and they mentioned the application deadlines in their newsletters to the 1500 schools with Indian students. In addition, the BIA Area Offices notified the BIA schools of the availability of funds under the new legislation.

As a result of these efforts, of the 10 proposals specifically targeted toward the Indian population submitted by institutions of higher education, five were funded under the Training and Demonstration Grants Program. Four of the five Indian projects are reservation-based. The Pierce College, Cheyenne River, and University of Oklahoma projects are providing services to BIA schools and dormitories. Two thousand four hundred Indian students from 12 public schools, two tribal schools, two BIA schools and two BIA dormitories will benefit from the projects funded by the Department of Education. The focus of these projects is to establish model programs with local schools and to provide inservice training for school personnel.

In those activities targeted at elementary and secondary programs in the Federal Activities Grants Program, four Indian projects were funded out of the 28 proposals submitted by tribes or tribal schools. The four projects include two tribally administered grants, Red Cliff and Ft. Belknap, one urban Indian alternative school operated by an Indian School Board, and one university-based project that will work with eight Indian schools. Four thousand seven hundred and thirty-five Indian students will benefit from these four projects representing 14 public schools, 12 tribal schools and four BIA schools. Of the currently funded nine Indian projects in both programs, a total of 7,135 Indian students will be served. These projects cover nine States and are providing drug education and prevention activities in public schools, tribal schools, BIA schools, and dormitories.

In another Department of Education program, the Fund for the Improvement of Postsecondary Education made grants to institutions of higher education to develop, operate, implement, and improve drug education and prevention programs for their students. Two of these grants went to colleges whose primary mission is to serve the American Indian: Bacone College and Oglala Lakota College. Both projects have community involvement as a major emphasis of their drug prevention programs.

In addition, the Department has also worked with a number of Indian schools, providing team training and technical assistance through the work of our regional centers. Five new cooperative agreements to operate these centers were signed this past week. Each center has the responsibility of monitoring its ten-state region for regional issues. We expect the centers to provide training to public schools that enroll Indians. In the past, the Midwest and Southwest Centers have provided training to Indian personnel.

These are some of the steps we at the Department of Education have initiated to help stem the tide of drug use among the young. They are important contributions. I think we are in agreement that the Drug Free Schools and Communities Act represents a milestone in the Federal campaign against drug use. The Department has implemented its program in a timely fashion. Most of the $200 million appropriated has been awarded. Resources are available--this is the year to get drugs out of schools.

While I have this opportunity I would also like to discuss our proposed amendments to the Anti-Drug Abuse Act of 1986. We believe these amendments include the elements essential to an effective Federal education policy to remove drugs from schools. They are meant to provide guidance, leadership, and direction.

Among other things, our amendments would require school districts applying for funds to explain, in their applications, the drug problems in their schools, as well as the policies, procedures, and programs they will adopt to eliminate those problems. In addition, the amendments would require districts to monitor regularly the effectiveness of their programs. In order to receive future funds, districts would have to show reasonable progress toward reducing their drug and alcohol problems, or show that they have altered ineffective strategies. In short, our amendments would require assessment, institute accountability, and require either progress or change. We are pleased that parts of these amendments have been incorporated into H.R. 5, the omnibus elementary and secondary education reauthorization bill passed by the House, and we are hoping for similar action on the Senate side. But I believe that their inclusion in their entirety would be in the best interest of creating a forceful program for helping to remove drugs from schools. The principles underlying our amendments--assessment and accountability--are already accepted as fundamental to sound policy for education in general.

In addition to the Departmental efforts, Education is a member of the National Drug Policy Board and the lead agency for Prevention Education. This activity has created an additional opportunity for us to coordinate with the staffs of many agencies including the Bureau of Indian Affairs. As a member of our Prevention Education Committee, BIA has contributed to the overall strategy of our Committee.

We are also working on the upcoming White House Conference for a Drug-Free America which will be held in Washington, D.C. on February 28-March 3, 1988. A series of six Regional Conferences is being held during the months of November and December. In providing names for consideration for the conferences, we have been in contact with the National Advisory Council on Indian Education to obtain names of members of the Indian community who would be interested in attending these conferences.

We have learned a lot over the past year and a half about what works and what does not work in preventing student drug use. We know that the best hope for reducing student drug use is a comprehensive strategy at the local level. Efforts to prevent, reduce, and eliminate drug use must include the commitment and involvement of parents and communities. Many of the projects I mentioned earlier, that are specifically targeted for the Indian community, include these essential elements. We look forward to evaluating their effectiveness as we proceed with our monitoring efforts over the next year.

Thank you for the opportunity to address the Committee. We look forward to working with you toward our common purpose: removing illegal drugs from our schools and from the lives of our children. I would be happy to answer any questions you may have.

DRUG-FREE SCHOOLS AND COMMUNITIES ACT OF 1986
STATE GRANTS: FISCAL YEAR 1987

State	Total Allotment (100%)	Allotment for State and Local Educational Agencies (70%)	Allotment for Governor (30%)
Total	$159,101,000	$111,370,700	$47,730,300
ALABAMA	$2,760,904	$1,932,633	$828,271
ALASKA	$795,505	$556,854	$238,651
ARIZONA	$2,018,106	$1,412,674	$605,432
ARKANSAS	$1,611,093	$1,127,765	$483,328
CALIFORNIA	$15,598,768	$10,919,137	$4,679,631
COLORADO	$2,007,930	$1,405,551	$602,379
CONNECTICUT	$1,872,259	$1,310,581	$561,678
DELAWARE	$795,505	$556,854	$238,651
FLORIDA	$6,074,667	$4,252,266	$1,822,401
GEORGIA	$4,032,819	$2,822,973	$1,209,846
HAWAII	$795,505	$556,854	$238,651
IDAHO	$795,505	$556,854	$238,651
ILLINOIS	$7,478,862	$5,235,202	$2,243,660
INDIANA	$3,741,127	$2,618,789	$1,122,338
IOWA	$1,909,569	$1,336,698	$572,871
KANSAS	$1,536,474	$1,075,532	$460,942
KENTUCKY	$2,554,006	$1,787,804	$766,202
LOUISIANA	$3,225,577	$2,257,904	$967,673
MAINE	$795,505	$556,854	$238,651
MARYLAND	$2,659,151	$1,861,406	$797,745
MASSACHUSETTS	$3,401,949	$2,381,364	$1,020,585
MICHIGAN	$6,179,812	$4,325,867	$1,853,945
MINNESOTA	$2,689,677	$1,882,774	$806,903
MISSISSIPPI	$1,953,662	$1,367,563	$586,099
MISSOURI	$3,188,268	$2,231,788	$956,480
MONTANA	$795,505	$556,854	$238,651
NEBRASKA	$1,058,234	$740,764	$317,470
NEVADA	$795,505	$556,854	$238,651
NEW HAMPSHIRE	$795,505	$556,854	$238,651
NEW JERSEY	$4,639,947	$3,247,963	$1,391,984
NEW MEXICO	$1,024,316	$717,021	$307,295
NEW YORK	$10,874,028	$7,611,819	$3,262,209
NORTH CAROLINA	$4,015,861	$2,811,103	$1,204,758
NORTH DAKOTA	$795,505	$556,854	$238,651
OHIO	$7,092,200	$4,964,539	$2,127,661
OKLAHOMA	$2,170,738	$1,519,518	$651,220
OREGON	$1,708,454	$1,195,918	$512,536
PENNSYLVANIA	$7,231,262	$5,061,882	$2,169,380
RHODE ISLAND	$795,505	$556,854	$238,651
SOUTH CAROLINA	$2,289,448	$1,602,614	$686,834

UNITED STATES DEPARTMENT OF EDUCATION
WASHINGTON, D.C. 20202

OFFICE OF THE SECRETARY

DEPARTMENT OF EDUCATION PROGRAMS to implement the DRUG-FREE SCHOOLS AND COMMUNITIES ACT

On October 27, 1986, President Reagan signed the "Anti-Drug Abuse Act of 1986" into law. The Department of Education is responsible for administering Subtitle B of Title IV of that Act: the Drug-Free Schools and Communities Act of 1986 (the Act). The major components of the Department's programs and points of contact are listed below.

State and Local Grants Program: This is a formula grant program which allocates funds to States based on school-age population. Each State's allocation is divided between the State education agency (70%) and the Office of the Governor (30%). The SEA must allot at least 90 percent of the funds it receives to local education agencies to improve anti-drug abuse education, prevention, early intervention, and rehabilitation referral programs. The Governor provides financial support for anti-drug abuse efforts to community-based organizations. At least 50% of the Governor's funds must be used for programs for high-risk youth. All the States have received their allocations (Dick Hays, 732-4599).

Audiovisual Grants Program: Up to 8 awards will be made at the end of November to develop and distribute audiovisual materials to elementary and secondary schools for drug abuse education and prevention activities. These materials will be close-captioned videotapes with brief teacher guides. The tapes will be distributed to schools in August 1988 (Lou Mathis, 732-4637).

Grants for Institutions of Higher Education (IHEs): Responsibility for the implementation of this program is divided between the Fund for the Improvement of Postsecondary Education (FIPSE) and the Secretary's Discretionary Fund (SDF). FIPSE has made 92 grants to institutions of higher education to develop, operate, implement, and improve drug education and prevention programs for students enrolled in institutions of higher education (Ron Bucknam, 245-8100). SDF has responsibility for awarding grants to support preservice or inservice personnel training or demonstration programs in drug and alcohol abuse education and prevention for use in elementary and secondary schools. Forty-one grants were awarded in September (Bill Wooten, 732-4377).

Programs for Indian Youth: This program is administered under a Memorandum of Understanding between the Departments of Education and Interior. Anti-alcohol and drug abuse education and prevention services will be provided to Indian children on reservations attending elementary and secondary schools which are operated by the Bureau of Indian Affairs (Dick Hays, 732-4599).

Programs for Native Hawaiians: The Governor of Hawaii designates organizations to receive funds for drug prevention and education activities. The organizations which are eligible are those that primarily serve and represent Hawaiian natives (Dick Hays, 732-4599).

- Schools Without Drugs is in its third printing--more than 1.7 million copies have been distributed to date.

- The Office of Educational Research and Improvement (OERI) is currently supporting four initiatives designed to increase the amount of information available about drug abuse education and prevention

    - Drug-Free Schools Recognition Program. The Drug-Free Schools Recognition Program will operate in a manner similar to the Department's School Recognition Program, though it will receive guidance from an advisory group consisting of experts in the area of drug and alcohol abuse. Nominated schools will be reviewed by an appropriate panel, and those schools or programs selected for recognition will be honored at ceremonies in Washington, D.C. in late May 1988. In the year after the recognition ceremonies, the Program will sponsor 5 regional conferences on creating drug-free schools (Shirley Curry, 357-6134).

    - Network of Drug-Free Colleges. OERI will support development of a national network of colleges committed to eliminating drug abuse on their campuses. Initial networking efforts will focus on four year residential colleges so that information on comparable problems may be shared. The Network will be formed during the '87-'88 school year, with a national forum on the program to be held in the fall of 1988 (David Mack, 357-6117).

    - New Research Perspectives on Student Drug Abuse. During the fall and winter of 1987, 8 to 10 leading scholars and researchers will reflect on the drug issue and produce papers on a creative research agenda that will assist the efforts to eliminate drug abuse in schools. From March to May 1988, OERI will, with help from the Office of Personnel Management (OPM), host a series of workshops at which several of the researchers will present and discuss their papers (Ron Pedone, 357-6233).

    - Drug Abuse Curricula Criteria. OERI will develop, produce, and disseminate a guide to help school building and school district staff select and implement substance abuse curricula in elementary and secondary school. This guide will become available in August 1988 (Nelson Smith, 357-6187).

For further information on any of the activities summarized above, please call the appropriate contact person.

Regional Centers Program: The Department of Education has awarded five cooperative agreements to fulfill the requirements of the Act. The law authorizes the Department to support these regional centers to: (1) train school teams to assess and combat drug and alcohol abuse problems, (2) assist State educational agencies in coordinating and strengthening alcohol and drug abuse education and prevention programs, (3) assist local educational agencies and institutions of higher education in developing training programs for educational personnel, and (4) evaluate and disseminate effective substance abuse prevention programs.

A portion of the funds under the Regional Centers Program is being set aside for a project to provide support to the five regional centers in carrying out their responsibilities. Activities for this project include collecting and disseminating information on regional center activities, collecting and disseminating information on model alcohol and drug education and prevention activities, providing technical assistance to the centers in carrying out their responsibilities, and coordinating and supporting national workshops and conferences (Dick Hays, 732-4599).

Federal Activities: The Department is supporting a number of projects in this category.

- The Secretary's Discretionary Fund under its Federal Activities Grants Program supports model development, dissemination, technical assistance, and curriculum development activities for drug and alcohol abuse education and prevention. Thirty-eight awards have been made to State educational agencies, local educational agencies, institutions of higher education, and other nonprofit agencies, organizations, and institutions (Bill Wooten, 732-4377).
- The Challenge is the Department's program to encourage individual schools and school districts to sign a compact with representatives of school, home, and community to initiate or sustain a program based on the twelve principles in the handbook, Schools Without Drugs, to keep their schools drug-free and to become part of a national network of drug-free schools. As of the end of October, 804 schools and 157 school districts are members (Gary Hanna, 732-4161).
- The Challenge Newsletter is the Department's bi-monthly newsletter which highlights successful programs, provides the latest research on effective prevention measures, and answers questions about school-based efforts (Dianne Carter, 732-3030).
- The Department of Education works with the Department of Health and Human Services to support the National Clearinghouse for Alcohol and Drug Information. The Clearinghouse staff responds to requests from schools for information and materials on drugs and prevention strategies, drug education curricula, model drug education programs, and referrals for assistance and resources (Dianne Carter, 732-3030).

TESTIMONY

PUBLIC LAW 99-570
OMNIBUS ANTI-DRUG ABUSE ACT OF 1986

WINNEBAGO TRIBE OF NEBRASKA
WINNEBAGO, NEBRASKA

NOVEMBER, 1987

TESTIMONY - DRUG OMNIBUS BILL

Public Law 99-570, the Omnibus Anti-drug Abuse Act of 1986 has provided Indian people with the opportunity to make a significant impact on the ravages of alcohol and drug abuse among the Indian adults and youth of this country. We wish to formally express our graditute to the U.S. Congress and especially Congressman Bereuter and Senator Daschle for their instrumental role in developing those portions of 99-570 directly relating to helping Indian youth.

Public Law 99-570 provides Indian people with the opportunity to develop prevention programs, education programs, intervention programs, outpatient programs, primary treatment centers, aftercare programs and training. Our main concern here is the funding and operation of a Regional Primary Treatment Center.

On a national basis the alcoholism death rate for Indian males is approximately 4.9 per 100,000 as compared to .2 per 100,000 for the entire United States. For Indian females, the death rate is 1.6 per 100,000 as compared .1 per 100,000 for the entire United States. Indian males die at a rate more than twenty times the national average and Indian females at a rate sixteen times the national average! Indian people between the ages of 15 to 24 have higher rates of death in light specific mortality rates - all alcohol related.

Ladies and gentlemen, this is a devastating tragic reality. To be even more concrete, at Winnebago, 1986 hospital statistics show that a higher than 10% of accident victims treated were alcohol related. Of that 10% nearly 50% were treated for injuries purposely inflicted by other persons.

Nearly 25% of the women pregnant during 1986, acknowledged alcohol use during their term.

From a law enforcement viewpoint, during the first six months of 1986, 24,000 incident contacts were reported. These contacts were 95% or 22,800 alcohol related. Of adult charges in court 87% were alcohol related. 90% of all juvenile cases were alcohol related.

In relation to Child Welfare, in the 177 new cases opened in 1987, all of the clients had established that their problems were rooted in chemical abuse.

These figures present a reality of individual and families suffering that we daily confront. Public Law 99-570 has given us the hope and the opportunity to make a direct and a dramatic postive change in this reality.

The Aberdeen Area Tribes were directed to submit Tribal Action Plans by the Area Offices (BIA and IHS) and all Tribes have done so. The plans include how each Tribe proposes implementing the bill on their reservation. Many included portions which referred to a Treatment Center. All plans deal with prevention, education, training, family involvement, community involvement and aftercare counseling for adults and youth.

TAP's listed the available community resources and letters of support were included to show the community support and awareness. The Winnebago Committee that was formulated also proposed a Regional Treatment Center which was written and submitted for.

TREATMENT CENTER

The Winnebago Tribe has learned, through experience in seeking treatment and counseling services for its youth involved in abuse of alcohol and drugs and other chemicals, that there are no services available for American Indian youth.

Therefore, over the past two years, Winnebago youth have been referred to an adolescent treatment program in a nearby city. What we have learned frcm involvement in that program as counselors and family members, is that there is a distinct difference in the type of needs of an adolescent and of an adult involved in alcohol abuse. There are elements of a modality which we plan to adopt and coupled with the overlay of the cultural and spiritual values of the Winnebago staff and consultants as well as the family and counselor involvement of tribal members of other tribes in the Aberdeen Area, we believe that we can develop a culturally appropriate treatment setting for adolescents.

Rehabilitation vs. habilitation: In treating adults one element of treatment is assisting the patient in re-learning social and interpersonal relationship skills one learned as a youth, so that the sober adult may find it easier to re-intergrate into his family and into his extended family and community. Once the adolescent becomes drug and alcohol-free, the youth must learn from scratch basic coping skills, basic socialization skills, healthy bases for developing friendships with their peers, abandoning the manipulative behaviors used on their peers and parents. In short, adolescent treatment will habilitate youth.

Urban vs. Reservation/Rural: Indian families have been moving to urban areas since 1953 in great numbers due to the Bureau of Indian Affairs "Relocation program". Second and third generations of Indian families now reside in urban areas. They are multi-tribal associations which may find it difficult to establish a tribal-cultural component which is acceptable and appropriate for their particular population. However, the Area and Regional Treatment Center concept can be manageable because it would be developed for tribes who have lived near to one another for longer periods of time, i.e. 100 years. Provided that it is based on a reservation.

Family-Orientation vs. Client-Center Therapy: For many years, the individual was sent away and secluded/isolated for treatment due to the belief that it was the individual who was sick or deviant. The simple absence of alcohol was thought to be the primary goal of treatment. Based upon experience and research, the field of alcoholism services now promotes the use of the total family in completing the diagnosis and treatment plan for individuals. Each patient is an integral part of a family who is basically affected by the nature of the total family dynamics. The family must know how it contributes to the alcohol abuse of its member as well as how it can contribute to the wellness of the individual member. This is the goal of our proposed treatment facility. Each and every patient must have family members present for at least one week of the 45/90 day treatment cycle.

Forty-five Days vs. Ninety Days Treatment Cycle: The patient requires approximately 14 days to simply metabolize the alcohol from the body. The body requires another 14 days to physiologically withdraw from the normal use of alcohol. The patient during this period is not emotionally and psychologically available for individual or family therapy. They are involved in fighting off the need and desire for the effects of the alcohol to which their body is accustomed. Psychological and educational evaluations may be conducted towards the end of this period and written treatment plans may be finalized emphasizing the individualized needs of each patient. Minimal socialization is begun with daily involvement in group activities with the other youth in treatment to developing a group environment/community environment.

After there is a sound community environment, then the intensive group and family therapy may begin. The patient has made a commitment to finish the program. The adolescent is very susceptible to peer pressure and within the community setting we anticipate using that to a positive end. Making the peer pressure a positive pressure to maintain sobriety, to developing healthy friendships, and to develop a more positive outlook on the world at large. Peers are the strongest motivator to face consequences, to rebut manipulative behavior, to learn how to choose positive, supportive friends as an alternative to using alcohol or drugs to obliterate loneliness or unmanageable personal problems. Given the above facts, a 90 day program would be more advisable to successful treatment.

Aftercare: Before any youth is accepted for admission his/her local counselor must make a commitment to provide the follow-up coordination of services to the youth and family in their own family and tribal community. Training shall be provided to all referring counselors/agencies in order to develop a cohesive network of services to all youth in the Aberdeen Area.

Cultural Values: As part of the development for a stronger self-image, each patient as part of their treatment plan shall consider their clan membership, regardless of Tribe. Each clan has a specific role and responsibility in the life of its Tribe and makes a specific, productive contribution to the functioning of the Tribe. As each individual learns or re-learns this as it pertains to himself/herself, we can begin to change their life script from a negative one of a "drunken Indian" to a positive one of a "contributor to the Tribe". Counselors will assist in translating that dormant part of their identity into a contemporary life goal.

As each tribe is able, spiritual leaders will be requested to provide regular workshops on a rotating basis to the youth in a group setting, or in an individual setting if the request is made. The workshop shall be an educational one, much as our children learned about the history and development of the tribe "from their grandfather's knee" long ago. Long ago, our teaching came from our grandparents and other elder relatives. Our teaching came in a loving, gentle manner, not in a dogmatic, dictatorial, regimental manner. Re-institution of some of the positives of historical, tribal life can be useful to our youth today, both individually and tribally.

These types of activities are more valuable than spending large amounts of money on modern recreation of video games, disco dancing and the like, which promote the use of alcohol and drugs in their lyrics. If we, as caregivers, promote the respect of our elders, this is the best role model to present to our youth, rather than paying lipservice and isolating one segment of our population from the other.

The realities of implementing a bill like 99-570 are complex and confusing at the level of reservations and tribal groups. It is possible to by-pass people who have an interest in the care and treatment of Indian adolescents.

If I can use my Tribe as an example I wish to point out some events which were a part of the Winnebago Tribal experience in the past year. Communications seem to have been impossible between our Area office and the Tribe (Winnebago) many factors contributed to this; the tight time-line which the bill was implemented under. A period of five days was given to our Coordinating Committee to develop a proposal for the Adolescent Treatment Center. If we had not had a working committee since October of 1986, we would have never been able to respond to the request. We had met throughout the summer, other small tribes in the nation did not even know that they had to prepare a Tribal Action Plan.

We were not the only small tribe who experienced a lack of communications from IHS Area Offices. The first meetings which took place in the Aberdeen Area did not include Winnebago. Because of the fast pace of the implementation and the confusion at all levels inferrences were drawn and acted upon without input from our small Tribe. We may also infer that this happened in other areas.

Each Area office has a mechanism in place which is utilized by federal agencies to communicate with Tribes. Unfortunately, this mechanism is replete with political considerations, in the implementation of 99-570, it is possible to ignore, or by-pass quality for quantity. In our area, all tribal people who work with alcoholism programs are concerned with establishment of a quality treatment facility for our youth. This necessitates a process whereby all tribal governments are allowed to hear the concerns of their people, if the process is not there to allow small tribes or Indian people to be heard despite political concerns, a vital link to the intent of the bill is severed from the process. This cannot happen if we Indian people are to take 99-570 and make it live in Indian communities throughout this nation.

We feel it is necessary to question the intent of IHS in our area. We have never been consulted with, we have been instructed, and we have complied. We have been given assurances by the Aberdeen Area office and several weeks later, were told that the assurances were not valid.

We have shared, with every Aberdeen Area Tribal Chairman, our proposal for a treatment center because we felt it was important that the Tribes in the area work together to achieve the intent of the bill. In requesting copies of the proposals which were forwarded to Central office for consideration in June, we had to talk with three different people and after the Tribal Council wrote a letter to IHS on September 8, 1987, we finally received copies of the proposals on September 24, 1987. We question the evaluating committee at the area level because we feel that the composition lacked any valid expertise in the treatment of adolescents for drugs or alcohol.

More recently our Tribal Council Vice-Chairman was invited to a Health Board meeting composed of all Tribal Chairmen where a vote was taken on site-selection, prior to any criteria from Central Office, where a vote was taken 6-5, and the decision to call the decision unanimous was condoned and approved of by the representatives of IHS who were present.

The Winnebago Tribe of Nebraska believes all people have something to contribute to the implementation of this bill. The problems of drugs and alcohol are universal and historical. A few people taking a vote on sites in not tribal involvement. Ways must be found to find the tribal people who are "in the trenches" within each community, these are the people who daily realize the possibilities of the bill. We must find the way, within ourselves to overcome the superficial concerns of tribal pride and consider all Indian people's input as valued and valid for the effective implementation of the bill. It is our sincere belief that the Indian communities in the Aberdeen Area are prepared and willing to work to achieve realistic quality of life for Indian people.

RECOMMENDATIONS

Selection Process of Primary Regional Treatment Centers

1. The process that is developed to select the PRT's must be fair and consistent to all Indian Tribes, large and small.
2. Tribal consultation must be incorporated in all phases of the process to select the PRT's. The Tribes should be allowed adequate time to consult on the selection process.
3. The process should be well publicized - Federal Register, giving Tribes adequate time to submit proposals, consult in Area Work Plans, respond to alternative plans to provide treatment to adolescents i.e. contract health service to already existing treatment programs.
4. Publish in the Request for Proposal in Commerce Business Daily.
5. Publish the Criteria for Selection Regional Drug Abuse Treatment Centers, the contracting process, and time frame for the process of selection.
6. The process should be closely monitored by the Senate Select Committee Oversight Committee to assure that the process is fair and consistent.
7. The process must strongly emphasize Treatment plans that are quality program that incorporate aftercare plan.
8. Any selection process must be weighted strongly in favor of the quality of the treatment center proposal

rather than buildings and other less significant elements.

SELECTION PANEL READERS - AREA AND CENTRAL OFFICE

1. If there is a request for proposals the panel that will review the proposals must have training and treatment skills specifically related to the specific needs of youth.
2. The panel that will review, evaluate and coordinate the treatment centers must have training specific to the needs of youth or have access to experienced personnel.
3. The selection panel should review the treatment centers that incorporate the specific needs of adolescents in all phases of treatment and aftercare.
4. The selection panal should review proposals that includes the family treatment concept that is culturally relevant.

If this plan is to happen it must be done in a fashion that is fair to all tribes; a mechanism in place that is conducive to the fairness needs to be in place so that we do not have the problems that we have had during round one of the process.

In conclusion, we wish to stress again and again the three words that sum up todays testimony. Perception - Indian people know the problems of adolescent drug and alcohol abuse because we live the problem. Expertise - Indian people have been treating their brothers and sisters who suffer from chemical dependency far, far more longer than the Indian Health Service. Fairness - Indian people practice fairness in their families and in their daily lives. We are asking this committee to assure us that our perception, our expertise and our fairness be understood so that all proposals be evaluated objectively and fairly so that the very best Regional Treatment Center be established to meet the needs of all Indian people.

TESTIMONY SUBMITTED TO THE SENATE SELECT
COMMITTEE ON INDIAN AFFAIRS
BY THE ALBUQUERQUE AREA TRIBAL COORDINATING
COMMITTEE REGARDING THE OMNIBUS DRUG ACT OF 1986.
SUBTITLE C THE INDIAN ALCOHOL AND SUBSTANCE ABUSE
ACT OF 1986-PUBLIC LAW 99-570

INTRODUCTION

This testimony is being presented by the Albuquerque Area Tribal Coordinating Committee (hereinafter "AATCC"), a consortium of twenty-six (26) federally recognized tribes located in the States of Colorado and New Mexico. The AATCC has been instrumental in the development of the P.L. 99-570 impact within the States of Colorado and New Mexico by being nationally selected for one of the Residential Youth Treatment Centers pursuant to Section 4227 of the Omnibus Drug Act.

Our representation has been an inter-tribal undertaking and has been continuously involved in the Memorandum of Understanding (MOA), submitting recommendations to the Indian Health Service and Bureau of Indian Affairs for a long term development utilizing a multi-disciplinary team approach. In addition, the AATCC has been instrumental in dealing with the efforts required by this law, but one that finds us with limited resources and faced with the importance of being creative and cooperative in our efforts.

The role of the AATCC has its roots in the P.L. 99-570 legislation as a natural and systematic response to the directives made by the Congress to the tribes and to the federal agencies for implementation of this law. We have met our share of obstacles in the coordination and cooperative efforts of our twenty-six (26) tribes in the challenge of being creative and innovative in the attempt of reducing alcohol and drug abuse within our Indian communities.

Our involvement has been consistent at every turn of the road regarding the events that were initiated since the promulgation of the Act. Our group has submitted comments to the Bureau of Indian Affairs and the Indian Health Service in the national Memorandum of Agreement that was required by the Act of the Bureau of Indian Affairs and Indian Health Service. We further were involved in the local Albuquerque Area level with our involvement with the Organization Master Action Plan (OMAP) and the local OMAP by submitting comments to the respective area offices of the Bureau of Indian Affairs and Indian Health Service. It is our purpose and attempt to initiate and promulgate a multi-disciplinary team approach to our problems of alcohol and substance abuse that face our youth and that have been plaguing our Indian communities for numbers of years.

As a further example of our intertribal cooperation, the Albuquerque Area has utilized the University of New Mexico-Continuing Education Division to meet the challenge of training and certifying our Indian alcohol counselors for their ability to be alcohol and substance abuse counselors. Each of the twenty-six (26) tribes was presented with the task of passing a separate tribal resolution indicating that each tribe would forego its prorated allocation of dollars, predicated on a ARAM/SURAM calculation, so that there would be a greater pool of funds. By doing this cooperative effort, we are now able to provide each of the twenty-three (23) involved tribes the ability to have their staff trained and certified as alcohol and/or substance abuse counselors.

It has been our intent from the very beginning of the development of the AATCC in conjunction with the P.L. 99-570 to implement more local tribal control and more community orientated approaches in dealing with Indian health problems. Yet, we are finding that we are still having a great amount of difficulty dealing with the bureaucratic policy that has been a stone wall to our success. In particular, the local and central offices of the Bureau of Indian Affairs and of the Indian Health Service seem to have no sense for what problems exist at the community levels.

Our position is to maintain and develop a true sense of community policies that adequately and accurately reflect the true problems experienced by our Indian people who reside on and off the reservation communities.

Due to the limited amounts of finances, as well as the attempt of all our voices being put together as one, the AATCC is submitting these written comments for the Congressional record established herein regarding P.L. 99-570, and further wish to support all of those tribal initiatives that are being presented to this Senate Select Committee regarding the overall theme and appropriations necessary to make this piece of legislation a reality throughout Indian country and the United States.

I. LOCAL TRIBAL INITIATIVE

As recited above, the AATCC has had an excellent success rate notwithstanding the obstacles that were faced concerning appropriations and other economic resources. In spite of the few dollars made available, the AATCC was able to successfully meet to select the Regional Youth Treatment Center that was selected nationally as one of the twelve (12) sites. In addition, the AATCC was able to coordinate the Community Education and Training dollars by utilizing the University of New Mexico for a training and certification program. This undertaking must be compared to the IHS mandated "Three Day Orientation" that was to be provided only. Thus, the AATCC was able to provide the guarantee of quality health care that Congress has indicated by promulgation of the Act.

We are presently trying to address a Juvenile Detention Center mandated by the Act. The Albuquerque Area did have an opportunity to work with the State of New Mexico in a potential lease arrangement regarding an existing facility, but the Bureau of Indian Affairs Albuquerque Office literally "dropped the ball" in the handling of their law enforcement liaison services with the State of New Mexico. In any event, the AATCC will, nonetheless, continue to identify other resources available that will be utilized on a coordinated, cooperative basis both with the State of New Mexico, the federal agencies, and tribal facilities and programs.

It is further important to note that the Bureau of Indian Affairs both nationally and locally, has not lived up to the requirements set by the Congress in the promulgation of the Omnibus Drug Act. The area of juvenile detention has been completely absent of Bureau (BIA) involvement and they have further demonstrated no direction or leadership in the development of these necessary and mandated programs.

The AATCC would like to make it clear, that while the appropriations necessary for this Act are overwhelmingly needed, that in spite of the few dollars available, the AATCC has pulled together to make the concerns of alcohol and substance abuse a number one priority for our Indian communities.

II. PRESENT APPROPRIATIONS

With the promulgation of P.L. 99-570, it was abundantly clear to the tribes in the Albuquerque Area that the appropriations necessary to drive economically this piece of legislation were not present. The problems of alcoholism and drug abuse are so pervasive among the reservation and off-reservation populations that the appropriations generated by the Act are totally inadequate. For purposes of establishing this significant piece of federal legislation, the necessary appropriations to make this legislation a realistic goal requires a substantial increase in federal dollars to be made available to the tribes and our program initiatives, the states, and the federal agencies who serve the Indian communities.

In this P.L. 99-570 undertaking, the Albuquerque Area Tribal Coordinating Committee, with representatives from the nineteen

(19) New Mexico Pueblos, Ute Mountain and the Southern Utes, the Mescalero and Jicarilla Apache Tribes, and the Navajo communities of Alamo, Ramah, and Canoncito, work hand in hand with all of the twenty-six (26) tribes in New Mexico and Colorado, to establish a precedent in the inter-tribal working relationship necessary to have been nationally selected for a Regional Treatment Center, Section 4227. This Regional Treatment Center (RTC) is one of two (2) selected nationally as a demonstration and model treatment center for purposes of treating our Indian youth who are alcohol and substance abusers. It was only because of an established IHS hospital facility that enabled the Albuquerque Area Tribal Coordinating Committee to look for the least expensive renovation and rehabilitation dollars necessary to qualify for a Regional Treatment Center. It is obvious to us, as well as to other groups throughout Indian country, that there may be a significant problem in establishing these facilities in the tribal/regional areas because the appropriations necessary to fund twelve (12) Regional Treatment Centers may not, in fact, exist. Unless the adequate appropriations are available, the legislative requirements for facilities development may not be realized.

It is overwhelmingly clear in reviewing Section 4202 of P. L. 99-570 how Congress found and declared that the highest incidences of the causes of death among our Indian communities is predicated on alcohol and drug related injuries; that Indians between the ages of fifteen and twenty-four are more than two times likely to commit suicide than the general American population and approximately 80% of those suicides are alcohol related; and, that the IHS and the Bureau of Indian Affairs, who are charged with the treatment and rehabilitation efforts, the social services and law enforcement efforts among Indian people, are not fulfilling their statutory requirements.

In spite of all of the findings and declarations made by the Congress, the dollars necessary to fund theses kinds of acclamations are sadly short sighted. For example, Section 4206 of P.L. 99-570, "Tribal Action Plans", only provides $1,000,000.00 as the authorized appropriation for 1987, 1988, and 1989 to provide the technical assistance to the tribes for development of these Tribal Action Plans.

Similarly, appropriations provided pursuant to Section 4213, "Emergency Shelters", declares only $5,000,000.00 for each of the fiscal years 1987, 1988, and 1989 for the planning, design, construction, and renovation of Emergency Shelters or Halfway Houses to provide this emergency care for our Indian youth. In addition, the same provision of the Act on Emergency Shelters only authorizes an appropriation of $3,000,000.00 for each of the fiscal years, 1987, 1988, and 1989 to operate these Emergency Shelters.

These dollars are supposed to cover all of the fiscal requests throughout Indian Country. A multiplier of four would be an appropriate inflator of the true costs associated with fulfilling this legislation.

A similar underappropriated section of the Act is "Juvenile Detention Centers", Section 4220. Congress, while indicating the need for such Juvenile Detention Centers, nevertheless, appropriated only $10,000,000.00 for construction and renovation for each of the fiscal years 1987, 1988, and 1989, and only $5,000,000.00 for staffing and operation for each of the fiscal years 1987, 1988, and 1989. These underappropriated provisions of the Act clearly deprive the Tribes, as recipients of this federal legislation, the appropriate means by which to establish and create these provisions vitally needed for our reservation and off-reservation communities.

The funding for the Regional Youth Treatment Center, Section 4227, only appropriates $6,000,000.00 for the construction and renovation of these residential treatment centers and $3,000,000.00 for staffing for each of the fiscal years 1987, 1988, and 1989.

Such impressive legislation requires impressive appropriations. To deprive the tribes of these appropriations, in light of a very carefully detailed piece of legislation, is contradictory and further exacerbates the conditions of alcohol and substance abuse found within our reservation and off-reservation communities.

While the AATCC is cognizant of the need for inter-tribal cooperation and coalition development, we, as the twenty-six (26) tribes representing New Mexico and Colorado, nonetheless, are faced with extremely low financing by virtue of this Act. Moreover, even with the coalition development of the twenty-six

(26) tribes as an inter-tribal consortium, we are still faced with the necessary appropriations to address our alcohol and substance abuse problems.

We share with the Congress in their concern for our youth and we similar share with you in the scope and intent of the Act. However, when our needs are translated into real dollars by virtue of the preparation and presentment Tribal Action Plans, we are faced with the overwhelming problem of restricted funding to fit the immediate needs of our reservation and off-reservation communities.

Similar to every reservation and off-reservation community throughout the United States, the AATCC is aware of the ARAM/SURAM formulas utilized in the economic analysis for funding of the alcohol and substance abuse programs pursuant to this Act. Yet, these economic indicators do not consider the many off-reservation and urban Indian populations who are similarly entitled to the benefits of this Act. Predicated on such formulation and costs, the Albuquerque Area Tribal Coordinating Committee is comprised of a large reservation based population, yet has a similar need for off-reservation funding sources that are made available by the State block grants.

Our population figures are not in agreement with those of the Bureau of Indian Affairs and the Indian Health Service. It appears that there are three, or perhaps four, sets of population figures utilized by the BIA/IHS agencies when disbursing the funds for tribal programs. Moreover, there is a high incidence of "political events" found within BIA/IHS that reach and control those "local" economic calculations behind the final contract awards.

II. ECONOMIC ALLOCATORS

Pursuant to the recent Indian Health Service economic methodology regarding the disbursement of alcohol and drug abuse dollars, (ARAM/SURAM) the Tribes are now being faced with a variety of formulas including Years of Productive Life Lost (YPLL), Alcohol Related Years of Productive Life Lost (ARYPLL), and a whole panoply of "economic calculations". For example, the data received from the ATGS Indian Health Service forms are essentially geared to review the likelihood of funding and continued funding by IHS. There may be problems, however, in ascertaining whether the ATGS reflects the proper evaluation of services rendered by a contract from the IHS, yet such "data" acts as the prerequisite in determining contract awards.

Such confusion has lead the Tribes to be manipulated by the economic formulas and indicators used to substantiate a grant and/or award calculations. What once was a political force in the distribution of funds has now become a political and economic force, leaving the Tribes subject to mathematical formulations which are removed from real life allocators.

The AATCC has been struggling with the local Albuquerque Area IHS in attempting to get a uniform and accurate methodology to be utilized. We have discovered that the Denver population served by the Albuquerque IHS are not being counted as part of the population base for those contract dollars received from the Central Office. It is further distressing to us to find that the Pueblo of Isleta and the Navajo community of Canoncito have been unable to obtain alcohol and substance abuse contract dollars, but yet their populations are being included in the overall population base that the Albuquerque Area IHS submits to the Central Office.

We are cognizant of the national economic allocators used by IHS in their budgeting process. We are committed to require the Albuquerque Area IHS to similarly utilize the ARAM/SURAM and not allow the political arena to dictate the economic allocators. We, therefore, urge the Congress to implement the necessary provisions of the Act to allow a true sense of tribal initiative in the development of the economic allocators necessary to operate our Indian programs. We further urge the Congress to order the Indian Health Service and the Bureau of Indian Affairs to make as a condition precedent the requirement that the Tribes be allowed to participate on an equal basis with the federal agencies. The Tribes are ready for the challenge and it is up to this Congress to meet this challenge head on.

III. TRIBAL INITIATIVES

The course of Indian self-determination regarding health care and health care delivery has reached an accelerated point. Over the years and throughout Indian country, tribes are enabled now to deal effectively with the problems facing their reservation communities. Having to overcome the bureaucracy of the Bureau of Indian Affairs and the administrative costs related to the health care found within the Indian Health Service, the tribes are in a better position to directly contract with the United States than to have to administer and filter these funds through federal agencies. These comments are similarly geared to the State governments who look to receive a whole host of indirect cost rates which effectively deprive the tribes of their direct service(s) dollars.

For example, the Albuquerque Area Tribal Coordinating Committee is now considering the possibility of contracting directly with the Indian Health Service for the Alcohol and Substance Abuse related programs for the Albuquerque Area. This would eliminate the largest expense item of the IHS administrative costs relative to direct services of the P.L. 93-638 funds and could free up approximately twenty percent (20%) of the yearly allocations made to the Albuquerque Area. Such calculations can certainly be applicable to other areas of Indian health care and health care delivery systems. These administrative costs should be closely scrutinized by Congress to allow tribes the ability to directly operate our own health care programs. To have the tribes incumbent upon the IHS and BIA, where in fact those costs are administratively top heavy, is an expensive undertaking and one which can certainly be avoided.

In examining the FY 87 P.L. 99-570 Indian Health Service budget, it is noted that the President's proposed FY 88 budget is clearly less than that proposed by Indian Health Service. There was excluded $10,000,000.00 for Catastrophic Health Care funds which is a cost that is subject to great comment throughout Indian country.

Attempting to put our serious injuries and need for intensive medical care into an economic formulation is all too typical of the "economics" used by the American society in dealing with health care provisions. We, as Indian people, cannot watch our people die or suffer from a catastrophic injury based on the funding excuses rendered by Indian Health Service. If the Indian Health Service would free itself from the all pervasive administrative costs and other expenditures before the funds flow to the tribes, then direct services for each of the reservation communities could be actualized instead of being penalized for such catastrophic and similar type health care funding requests.

IV. TRIBAL ACTION PLANS

It appears for the first time in American legislation that the Congress has sought the input from tribes regarding their health care plans concerning alcohol and substance abuse. In examining Section 4204 of P.L. 99-570, each federally recognized tribe is authorized to prepare a Tribal Action Plan for the purposes of defining agency action and assistance to a tribe in its attempt to conquer and eradicate the incidences of alcohol and substance abuse. In further examining Section 4206 of the

Act, each tribe is to establish a Tribal Coordinating Committee with its representatives being members of that particular tribe, as well as from the federal agencies who service the health care needs of that tribal community. In addition, the Tribal Action Plan is to formulate a plan in which to undertake the treatment of alcohol and substance abuse among its particular community members.

A clear provision of the Tribal Action Plan will, nonetheless, be a budget preparation for each and every tribe to present to their Area IHS and BIA offices for the "requisite" funding. It could very well be that at this time next year, or within six (6) months of the date of these hearings, that the Congress may receive over 300 tribal TAP's representing those federally recognized tribes in the United States and Alaska. It would certainly be an interesting day when the tribes were to collectively present the Congress with each one of the Tribal Action Plans developed and engineered to meet the P.L. 99-570 requirements. Each and every one of these Tribes will have thought through their individual tribal problems related to alcohol and substance abuse for each of their reservations and will have conducted a "budget work up" of the manner, scope and dimensions that each of their Tribal Action Plans will take.

To have the tribes generate Tribal Action Plans without the Congress reviewing those related costs in the eradication of Indian alcohol and substance abuse would be both confusing and inefficient. The Congress will be faced with the overwhelming task of hearing and calculating the fiscal requirements necessary to accomplish this legislation. For the Congress to require a Tribal Action Plan, yet not consider the overall funding impact that such Tribal Action Plan may undertake, would generate unnecessary futility for the tribes. Therefore, the tribes, acting through agencies such as the National Indian Health Board, the National Congress of American Indians, and other tribal representatives, will place before this Congress, the Tribal Action Plans generated by each and every tribe for the purposes of reviewing the overall price tag necessary to assist the tribes in the elimination of the severe alcoholic and substance abuse problems that are plaguing our Indian nations.

V. RESERVATION AND OFF-RESERVATION APPROPRIATIONS

As part of this testimony, the Albuquerque Area Tribal Coordinating Committee wishes to impress upon the Congress the importance of considering the role of off-reservation as well as on-reservation enrolled Indian members. Too often the on-reservation persons are the only ones counted for reasons of the IHS ARAM/SURAM calculations. It is abundantly clear that the United States has a significant urban Indian population that must receive the necessary appropriations to fight off the incidences of infant morbidity, alcohol and substance abuse, and the whole array of diseases and physiological and psychological problems affecting Indian communities. The on-reservation and off-reservation Indian people must be treated similarly to allow a consistent and realistic appropriation cycle to adequately address the many health needs of our Indian people. Moreover, the on-reservation and off-reservation persons comprise the true picture of the needs of the necessary funding picture for the Indian Health Service as well as the Bureau of Indian Affairs. Therefore, it is the position of the AATCC that the Congress carefully examine and find that the off-reservation, as well as the on-reservation, Indian population be considered in the overall appropriations necessary to achieve the mandates of P.L. 99-570.

VI. CONCLUSION

The Albuquerque Area Tribal Coordinating Committee has presented these comments, recommendations and orientations to the members of Congress to review and undertake the necessary effort to accomplish these requests and recommendations. We are presently faced, as a nation of Indian people within this Nation, with the immediate need to eradicate the overwhelming horrors of alcoholism and substance abuse found within our Indian communities. We have the highest incidents of suicide among any other target population in the United States and we deserve the necessary appropriations to make the P.L. 99-570 legislation a realistic undertaking. Congress saw fit to enact this Act and it now needs to see fit to put the necessary appropriations into place.

It is our position that the dollars necessary to fund this Act, along with several other important pieces of health care legislation, can be found in the FY 88 Budget and budgetary processes. The total costs available for the eradication of alcoholism and substance abuse within our Indian communities is a price tag that must be paid to bring our target population back into the more "realistic" numbers, as other racial and minority groups within American society. The American Indian communities have long suffered and will continue to suffer unless the necessary appropriations are made.

As part of these hearings on P.L. 99-570, the AATCC makes the recommendation to this body that it also solicits testimony from those regional groups throughout the United States and Alaska by making themselves available for such regional testimony. Many of our concerns and ideas can be better appreciated by this Senate Select Committee by making its presence known and available throughout the United States and Alaska. We wish to make our voices heard and to educate the Congressional Committees on the importance of the appropriations relative to this Act.

We believe that the voices still to be heard in the Indian communities are ones that will instruct, help, and advise this Congressional body to make the necessary events occur so as to achieve the best net result of the Indian Alcohol and Substance Abuse Act of 1986.

Should the Senate Select Committee require further testimony of request appearance for any other hearings, please contact Mr. Herman Agoyo, Chairman, All Indian Pueblo Council, Albuquerque, New Mexico and/or Mr. Everett Vigil, Co-Chairman, Albuquerque Area Tribal Coordinating Committee, Albuquerque, New Mexico.

We thank you for your time, consideration, and assistance.

SUPPLEMENT 1

"PROBLEM STATEMENT OF THE THREE AFFILIATED TRIBES"

Excerpted from: "Tribal Action Plan." Draft Form, Submitted to Aberdeen Area Office, Indian Health Service, July 1987.

V. PROBLEM STATEMENT

Various statistics are available indicating the severity of chemical dependency on the Fort Berthold Reservation. The most recent data is presented below and originates from a variety of sources. These sources include statistical compilations by Indian Health Service, Bureau of Indian Affairs, Tribal Studies, other Federal and State agencies, personal interviews and testimonies. Chemical dependency impacts upon the people as exhibited in the following areas: Health; Education; Alcoholism Service Delivery; Family and Social Services; Law Enforcement; Judicial Services.

A. Health

The age adjusted death rate statistics for alcoholism on the Fort Berthold Indian Reservation is 200.6 per 100,000 population. These same statistics list a comparison of the Fort Berthold rate to other population sectors. (1)

DEATHS PER 100,000 POPULATION

Fort Berthold	200.6
Aberdeen Area	67.6
American Indian	35.8
U.S. All Races	6.4

Other data shows that Fort Berthold has the highest alcoholism death rate in the Aberdeen Area. (2)

Chronic liver disease/cirrhosis data is another indicator of alcoholism. The Fort Berthold Reservation age adjusted death rate for this condition is also the highest rate for the Aberdeen Area. The following chart is indicative of the severity of the problem. (3)

DEATHS PER 100,000 POPULATION

Fort Berthold	150.76
Aberdeen Area	72.1
American Indian	31.0
U.S. All Races	10.5

Alcohol is known as a modifiable risk factor for infant mortality. (4) A high infant mortality rate characterizes the Fort Berthold population. This is proven by the Indian Health Service statistics for crude infant mortality rates for 1981-1983 which lists Fort Berthold's rate as 30.5 per 1000 live births. (5)

DEATHS PER 1000 LIVE BIRTHS

Fort Berthold	30.5
Aberdeen Area	22.0
American Indian	11.0
U.S. All Races	11.5

The Fort Berthold Reservation does not have a hospital and is served by contract health care dollars. In 1985, it was estimated that one-fifth (1/5) of the total Fort Berthold Indian Health Care contract dollars were spent to treat conditions associated with alcoholism. (6) This high expenditure of contract health monies is another strong indicator of the severity of alcoholism on Ft. Berthold residents.

B. EDUCATION:

The Fort Berthold Reservation is served by six different school districts. Three of the schools are Bureau of Indian Affairs funded and three are not. There are approximately 900-1000 children attending school from grades K-12. Of this population, approximately 50% of the students are attending non-Bureau Of Indian Affairs (BIA) funded schools. In February, 1987 a reservation wide needs assessment was conducted in the schools. The ORBIS Associates indicated that respondents found the following to be problems for Indian students both in and out of school. (5)

1. Family Problems
2. Lack of discipline
3. Lack of parental support
4. Drugs and alcohol
5. Prejudice
6. Poor attitudes of students
7. Not enough recreational activities
8. Need for coping skills

The report indicated that social problems pose a serious threat to the educational process on the Fort Berthold Indian reservation. These problems are attributed to alcoholism and unemployment and are said to be exhibited in school as: lack of rest; poor attitudes; poor attendance; low achievement; students transferring from school to school; and discipline problems.

Mandaree and White Shield schools appear to have substance abuse programs that are functional. Staff at the Twin Buttes school indicated that the substance abuse program at their school was not functioning as it should. New Town provided evidence of seeking help for students with social problems, however, some parents viewed their substance abuse program as stigmatizing to students rather then helping. Parshall students surveyed stated that they were not getting any special assistance regarding substance abuse problems.

The ORBIS report is the first analysis of the schools with the five largest populations. Although the study did not look at the chemical dependency problems specifically, these problems emerged as needing further investigation. This data from the Orbis Associates Report verifies the severity of substance abuse in the schools.

C. ALCOHOLISM SERVICE DELIVERY

There is no accurate data available for the Fort Berthold Reservation regarding utilization rates for chemical dependency services. The Tribal Alcoholism Services contracted from Indian Health Service is very limited in scope. Because of the limited services offered, it is impossible to interpret the utilization rates as indicators of need.

The current Tribal Alcoholism Services are limited to outreach which IHS defines as:

> A service designed to reach into the community and identify individuals and/or families presently in need of intervention and treatment. Intervention in the early stages of involvement is stressed, information about community resources is provided and entry into treatment is facilitated through motivational counseling, referral and transportation. (7)

Outreach and referral to what? Tribal Alcoholism Services is limited by lack of financial resources to pay for treatment services. Therefore, an individual seeking help will more than likely be referred to the State Hospital in Jamestown, Veterans Facilities, or IHS funded treatment programs in distant communities.

Tribal Alcoholism Services are unable to pay for treatment and their services are underutilized. A majority employees have insurance and other Ft. Berthold residents are eligible for medical assistance through the state. Therefore, these individuals seek treatment independently and have no reason to access Tribal Alcoholism Services. The persons who receive treatment independently are not reported through the Alcoholism Treatment Guidance System (ATGS). This lack of reporting skews the actual number of Ft. Berthold residents receiving treatment.

A large proportion of the population afflicted with chemical dependency are individuals who fall between the cracks of service delivery. They are not eligible for third party payments of any kind and are reluctant to receive treatment from the State Hospital in Jamestown. These same people are often on waiting lists to enter treatment centers in distant Indian communities that do have IHS funded treatment. Payment for quality inpatient treatment services continues to be a critical unmet need for the Fort Berthold Population.

Quality assurance is a major problem for monitoring of treatment services received by the people of the Three Affiliated Tribes. This is apparent since the Tribes have no way of knowing where each tribal member receives treatment. This phenomenon becomes more complicated when you consider the numerous different facilities utilized. Presently, the Fort Berthold residents are served by approximately ten treatment centers. These include:

-Saint Josephs, Minot, ND

-Mercy Hospital, Williston, ND
-Mercy Hospital, Dickinson, ND
-Heartview Treatment Center, Mandan, ND
-Veterans Hospital, Fort Meade, SD
-Veterans Hospital, Fargo, ND
-Native American Human Services Center, Winnebago, NE
-Red Road To Recovery Center,Sargents Bluff, ID
-Thunder Child Treatment Center, Sheridan, WY

Outpatient treatment services are available at many hospitals in North Dakota. In addition the Human Service Centers provide outpatient programs to residents of the Ft. Berthold Reservation. However, the approximate distance from each community to the nearest outpatient treatment center is a round trip of 150 miles. The distance factor compounded by the need to attend these services twice a week and the depressed economy makes attendance of outpatient treatment very difficult.

Persons receiving inpatient treatment require aftercare as part of the continuum of care. However, the availability of aftercare services on the Reservation is limited. Aftercare plans are not coordinated with the Three Affiliated Tribes Alcoholism Services Program upon the client's return to the community. Distances to attend services in the metropolitan centers also makes this service inaccessible for most clients. Thus, only minimal aftercare services are presently available. This lack of services makes readjustment into the community difficult and a probable reason for the high recidivism.

It is recognized that chemical dependency is a family problem and that all individuals in the family need to be treated. The present service delivery system is a barrier to this philosophy of treatment. Although many families do participate in the treatment process, a significant number of others are unable to participate. Distance, compounded by the high poverty level, makes access virtually impossible for Indian clients and family members to receive services. This lack of family involvement decreases the chances that treatment will be effective.

Statistics provided by the Three Affiliated Tribes Alcoholism Services indicate an ATGS count of 380 contacts. Of these 380 contacts, there is an unduplicated count of 124 persons. Outreach, defined as motivational counseling to encourage the client to seek treatment, accounted for 27% of the total contacts. Approximately 23% of the contacts were for individual counseling and 24% were for traveling with or for the client. (7)

The nature of the service delivery system and the lack of a comprehensive ATGS information regarding the "real" picture at Fort Berthold precludes any information regarding recidivism rates. Information is not available regarding how effective the available off reservation treatment services are.

D. YOUTH AND FAMILY SERVICES

There are approximately 805 families residing on the Fort Berthold Indian Reservation. It is estimated that 228 families are currently in the breakup stage due to the effects of alcoholism. The Child Welfare component of the Tribal Social Services has an ongoing caseload of 180 cases.

Ninety-nine percent (99%) of these cases are directly attributable to chemical dependency. (8) Two child welfare workers are forced to handle this caseload of 180 clients. The alcoholism problem is impacting the social service delivery system by increasing the caseload.

The Three Affiliated Tribes, Child Welfare Program, caseworkers have identified 160 Indian children placed outside their natural home. The following list indicates the placements:

Boarding Schools	60
Residential Care/ Treatment Facilities	2
Legal Custody (foster care) of the Tribes	60
Indian Child Welfare (ICWA) Foster Care	38

This does not include the number of children in detention facilities or the number in voluntary placements "Indian Way". "Indian Way" being defined as parents placing their children with relatives voluntarily to raise.

Economic factors also influence the quality of life of families which in turn effects the alcoholism statistics. The unemployment rate of the Fort Berthold Reservation is 47.2 % according to the August 1986 Bureau of Indian Affairs (BIA) Report on Service Population and Labor Force. According to the Tribal Chairman, the unemployment varies seasonally with the rate reaching as high as 86% during the winter months. In addition to unemployment statistics, the 1980 census shows that the percentage of Persons below the Poverty Rate in that year was 13.0%. At Fort Berthold, 37.5% of the population or three times the national rate. The census also reported that the Average Per Capita Income nationally was $8,080 as compared to Fort Berthold's average income of $2,730. Fort Berthold's rate is only one-third the national average.

The number of single parents on the Fort Berthold Reservation is significantly high. An indicator of this is the large number of persons receiving Aid For Dependent Children payments. Listed is a table explaining the number of Indian clients as of March 1, 1987.

FORT BERTHOLD AFDC CASELOAD AND POPULATION COMPARISON

COUNTIES	CASELOAD INDIAN/TOTAL	CASELOAD INDIAN-PERCENT	POPULATION INDIAN-PERCENT
Mountrail	81/116	70%	12%
McLean	20/60	33%	4%
McKenzie	90/125	72%	12%
Dunn	25/45	56%	9%
TOTAL	216/346	62%	8%

* Caseload data unavailable for Mercer County

The Indian population of the four counties comprise 8% of the total populations. However, the Indian population accounts for 62% of the AFDC caseload.

Another indicator of the economic plight is the general assistance caseload. During the month of March 1987, the Tribal Social Services provided living allowances to 216 singles and families.

The Fort Berthold Coalition Against Domestic Violence identified 56 cases of adult abuse within families in the six month period between July 1986 and December 1986. It is estimated that alcohol was involved in the majority of the cases.

Teenagers becoming mothers is a problem on the Fort Berthold Reservation. It is known that infants born to young mothers are at risk. The most recent Indian Health Service statistics for Fort Berthold are 1983 and indicate births to mother's under age 20 comprised 28.4 % of all births. This is 17.8% higher then the state of North Dakota for that same age group the same year. Between the four year period of 1981-1984, the state of North Dakota documented only a 1% increase in said births. The Fort Berthold statistics indicate a 12% increase in births to mothers under age 20 between 1981-1983.

Services identified for youth are very limited. No data is available regarding how many adolescents were referred to treatment. In the New Town school district alone, nine students went to treatment in 1985-1986. Information is not available regarding the other five school districts. Heartview Treatment Center in Mandan, ND has the only inpatient adolescent treatment ward in western North Dakota.

There are limited services available for; chemically dependent adolescents, victims of child abuse and neglect, children living in homes of domestic violence and/or chemically dependent parents, or incest. Those services that are available are often hard to access because of limited financial resources. The state of North Dakota has identified this to be a concern also. The "Report and Recommendations of the North Dakota Commission on Mental

Health Services, December,1986" lists children (age 12 and under), adolescents (age 18 and under), and minorities (especially Native Americans) to have inadequate services and underutilization in the state hospital and regional human services centers. Recommendations made in the report in regard to these populations were.

1. Mental health services be improved for the underserved elderly, children, and adolescents.
2. Children and adolescents be given a visible service status within the Department of Human Services and programs be developed to enhance their mental wellness.
3. Services be provided by the Department of Human Services in conjunction and cooperation with other private and public agencies to all family members victims and perpetrators, experiencing violent behavior in their homes (sexual, child and spouse abuse).
4. Consulting services be offered through the human service centers to reservation agencies on the four reservations and assistance provided in the training of Native American counselors as a preferred policy alternative to direct outreach human service center services to reservation residents.

E. LAW ENFORCEMENT AND JUDICIAL SERVICES

The most recent Bureau of Indian Affairs Law Enforcement Services Data Printout reports were FY 1985. These reports documented 1,343 Indian Alcohol/Drug related arrests on the Fort Berthold Reservation. Drunkeness accounted for 659 offenses; 579 arrests were Indian males age 18 years and over; youth aged 18 years and under were, 65 Indian males, and 15 Indian females. Misdemeanor offenses, major offenses, and motor vehicle violations brought the total to 1,343 for the year.

Since January 1986, there have been ten (10) felony cases handled in federal court, eight (8) were alcohol related. In the first five months of 1987, twenty-four protection orders were issued by the tribal court to protect victims of domestic violence. Many of these incidences involve alcohol abuse. There have been an increasing number of incest reports being made which require investigation. Many of such cases occur in alcoholic families.

Chapter 4 of the Tribal Code has been cited as a hindrance to law enforcement. Resources for DUI evaluations has also been cited. Mechanisms to combat the DUI problem are limited, investigation and training in utilization of such programs as Counter Attack are needed.

Budget constraints are impeding law enforcement from providing adequate coverage and quality of services. In addition to the already mentioned lack of adequate facilities, lack of adequate staff to cover the communities is critical. Other needs include; various training (domestic violence intervention, neighborhood crime watch, investigations for child abuse and neglect, etc.), time manpower, and training in how to assist schools in developing programs addressing chemical abuse issues and prevention. The law enforcement staff has indicated that they consider chemical dependency as the single most destructive element plaguing the Fort Berthold Reservation.

The analysis of the available data presented here as the definition of the problem has identified the following areas of concern:

F. AREAS OF CONCERN

1. THERE IS A LACK OF COMPREHENSIVE, QUALITY, CHEMICAL DEPENDENCY SERVICES AVAILABLE TO MEET THE SEVERE NEED ON FORT BERTHOLD INDIAN RESERVATION.
   There are no chemical dependency treatment services and limited aftercare services available on the Fort Berthold Reservation. The geographically isolated communities of Mandaree, Twin Buttes, and White Shield are having difficulty accessing services.

2. THE FORT BERTHOLD INDIAN POPULATION UNDER AGE 20 COMPRISES 52% OF THE TOTAL POPULATION. ( ) HOWEVER, SERVICES ARE INSUFFICIENT TO MEET THE SPECIFIC NEEDS OF YOUTH AND THEIR FAMILIES.
   Youth and their families are experiencing significant social problems which are linked to chemical dependency.

3. SERVICE PROVIDERS AND THE COMMUNITY AT LARGE NEED TRAINING IN DEALING WITH THE PERVASIVE PROBLEM OF CHEMICAL DEPENDENCY IN ORDER TO MAKE PROGRESS TOWARD A SOLUTION.
   Community members need to become aware of the dynamics of chemical dependency and how it effects families. Other professionals need to be aware of how chemical dependency impacts them and how to intervene in the dynamics. Alcoholism counselors need to become certified as chemical dependency counselors. Chemical dependency counselors and social workers need to gain diagnostic and treatment skills rather then functioning solely as referral agents. Chemical dependency counselors need training to become proficient at using the Alcoholism Treatment Guidance System (ATGS).

4. THERE IS A LACK OF COORDINATION BETWEEN DIFFERENT SYSTEMS ON THE RESERVATION AS WELL AS AGENCIES PROVIDING AND MONITORING SERVICES. QUALITY ASSURANCE IS NOT POSSIBLE WITHOUT COORDINATION.

5. THE JUVENILE DETENTION FACILITY IS OUT OF COMPLIANCE WITH REGULATIONS AND IS NOT ACCEPTABLE TO DETAIN YOUTH.